



1991  
ADVISORY  
COUNCIL *on*  
SOCIAL  
SECURITY

**State Governments:  
The Effects of  
Health Care  
Program Expansion  
in a Period of  
Fiscal Stress**



December 1991  
Washington, DC



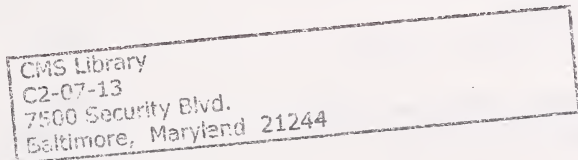
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# **State Governments: The Effects of Health Care Program Expansion in a Period of Fiscal Stress**

A Report of the  
Advisory Council  
on Social Security



December 1991  
Washington, DC

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# PREFACE

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The 1991 Advisory Council on Social Security was appointed by Health and Human Services Secretary Dr. Louis Sullivan in June 1989 to review the status of the Social Security and Medicare trust funds as well as to study a range of health care issues. The Council convened 14 meetings, and to assist in the Council's deliberations, substantive, scholarly investigations were undertaken on a broad range of health care issues. This report is one of seven issue analysis reports which were produced for the Council and helped provide an understanding necessary to make recommendations commensurate with the Secretary's broad charge.

The States' experiences shed valuable light on policy issues and serve as relevant background for national policy-makers. This report was intended to assist Council members in their understanding of the effects of the increase in health care costs on States from two different perspectives: Eight individuals involved in State budgetary decision-making processes provide a firsthand view of social spending and the stress that rising health care costs have placed on their budgets; and a national analysis of State budget decisions and the ensuing State tradeoffs in social spending is presented.

I wish to thank Victor Miller for his role as Project Director and editor of this report, as well as his contribution of one of the National Papers in this report, for without his effort this project would still be an idea. I also thank the other authors of the National Papers: Gwen A. Holden, Harold A. Hovey, and

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Connie Wessner, as well as the authors of the State Papers, Robert Bittenbender, Stephen E. DeMougin, John R. Fadoir, Stephen T. Golding, Merl Hackbart, Dale C. Hatch, Diane Stewart, James M. Verdier, and R. Jon Yunker.

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## EXECUTIVE SUMMARY

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Ten years ago, the Medicaid program was an important part of a multifaceted intergovernmental system. For example, 1979 Federal expenditures on Medicaid were \$12.4 billion, 2.5 percent of the Federal budget, while spending for Comprehensive Employment and Training Act (CETA) programs was \$8.7 billion. Transportation grants (highway, mass transit, and airports) totaled \$10.4 billion, general revenue sharing expended \$6.8 billion, and spending for Aid to Families with Dependent Children (AFDC) and related programs was \$6.3 billion annually. Grants-in-aid to State and local governments totalled \$82.9 billion, 16.5 percent of Federal spending.

By 1989, general revenue sharing and CETA had been terminated, transportation grants had increased to \$18.2 billion, AFDC-related programs cost \$11.2 billion, and Medicaid spending had soared to \$34.6 billion. Grants totaled 10.7 percent of Federal spending, and Medicaid had increased to almost 30 percent of Federal grants.

Medicaid spending for 1992 is now estimated to reach almost \$70 billion, double the level of 3 years previous, and may easily exceed that level. It has grown to almost 5 percent of Federal spending and will constitute an estimated 40 percent of Federal grants. It has grown from an important part of the intergovernmental flow to the overwhelmingly dominant feature. Even the massive new highway bill will result in annual expenditures less than one-third of Medicaid's, and that fraction will shrink rapidly. Medicaid has grown from a health financing program to the basic financial relationship between the Federal Government and the States.



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The growth of the program has been made possible at both the Federal and State levels by its entitlement status and by its shared responsibility. Just as Federal lawmakers are entranced by a program for which they only have to pay 57 percent of the costs, State lawmakers are fairly easily sold on new options for which they have to pay only an average of 43 percent. It should be noted that the Medicaid program is not an entitlement for the poor—there is no guarantee to anyone of health care. The entitlement is to the State (to receive matching payments) and to the provider (to receive reimbursement at some level).

This volume presents 12 papers that depict the recent growth of the Medicaid program from a variety of perspectives. Four provide a national view, while eight present case histories in specific States. These eight States were chosen to provide a diverse presentation of small and large States and geographic location.

The *Miller* paper provides a history of Federal grant-in-aid spending and documents the change described above. It then proceeds to describe some of the consequences. Medicaid growth has been accompanied by stagnation in Aid to Families with Dependent Children (AFDC) benefits. Over the decade of the 1980s, AFDC benefits in the average State (family of three) have fallen from 80 percent of the Federal SSI benefit (couple, living apart) to 60 percent. To the extent that explicit or implicit tradeoffs have been made, the paper concludes that the shift represents a tax on one group of poor to finance benefits for another group.

The *Utah* paper clearly recognizes that tradeoffs were made: Education and public assistance received lower funding, and there was a shift of resources within the health function itself. The *Connecticut* paper also lists the major casualties as education and public assistance. In the latter case, the enacted

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AFDC annual cost-of-living adjustment was repealed only 3 years after passage. By comparison, the *Delaware* paper concludes that few tradeoffs were made through 1991: Medicaid spending doubled over 5 years, but other social programs in the same agency grew by two-thirds.

Medicaid program costs have generally been underestimated at both the Federal and State levels, resulting in increases beyond the initial estimates for which tradeoffs have to be made. The *Hovey* paper describes this process at the State level. The net result in the majority of States is transfers to Medicaid without explicit changes in priorities. Hovey notes that the majority of States enacted major broad-based tax increases in 1990 and 1991, using as rationales (1) "keeping the doors open" and (2) supporting education and other State functions. He adds, "not one of those tax increases was justified to legislators who voted for it or to the electorate as providing money for Medicaid. Yet comparing the spending changes to the revenue changes suggests that much of the added purchasing power did go to Medicaid." Hovey concludes that this accretion of Medicaid costs represents a transfer of resources away from the middle class, threatening the legitimacy of government provision of resources.

The growth of entitlement spending at the State level is well described in the *Connecticut* paper. Eighty percent of the State budget is estimated to be "uncontrollable," and the budget process itself therefore allows growth. Since 1986, the Medicaid program has been the continued recipient of supplemental appropriations. Similarly, the *Indiana* paper shows that the entitlement nature of Medicaid permits it "at times to avoid immediate confrontation with other budget priorities." The Governor and Budget Director are statutorily authorized to augment the biennial appropriation to provide for under-funding that would jeopardize Federal reimbursement.

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Even with these augmentations, however, Medicaid still has received supplemental appropriations in even-numbered years.

Only State criminal justice expenditures have grown at a rate close to that of Medicaid. The *Holden* paper demonstrates that this growth has been fueled in a manner similar to that of Medicaid, in that explicit choices are rarely made. Decisions are first made in nonmonetary areas such as sentencing requirements and procedures. Only later are the capital costs of prison construction recognized, followed by the ongoing costs of operations. This process produces unavoidable costs that might not have occurred if initial tradeoffs had been made, with transfers to criminal justice from the balance of State spending and transfers to prisons within the criminal justice budget.

There are many reasons for State Medicaid growth. New mandates and options have been added to the system over the past 5 years. State perceptions of the programs were changed in some cases, such as the perceived benefits from increased maternal and child care. In addition, health costs are increasing rapidly for all levels of society, and Medicaid has shared in that growth. States have discovered that their purchasing power gives them formidable leverage in the marketplace, and the *Wesser* paper describes some of the strategies that have been pursued to control costs. These include movement to managed care systems such as prepaid health plans, waived case management, and preferred provider arrangements; utilization review; State planning; cost shifting; selective contracting; prospective reimbursement; and cost-sharing requirements.

The *Pennsylvania* paper details the extraordinary number of amendments to the Medicaid program which the State has made since 1986. Until recently, however, those changes have not required supplemental appropriations, as an emphasis has been placed on controlling costs. In particular, fees for

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services reimbursed under a fee schedule (most outpatient services) were held roughly constant until the 1991-92 budget. The *Indiana* paper describes a State that has had an expansive Medicaid program with severely constrained eligibility. As a result, few efforts have had to be made toward cost containment. The recently mandated eligibility expansions have generated substantial efforts, including the development of a nursing home reimbursement system and a DRG-type reimbursement to replace the current cost-based system. However, neither of these efforts has yet resulted in substantial reductions. The *Oregon* paper summarizes the most radical system for controlling costs, a reform that has not yet begun but is jeopardized already by a recent initiative guaranteeing increased State funds to replace locally constrained support for education.

States' abilities to finance the extraordinary growth of their Medicaid programs have been facilitated in most cases by strong own-source revenue growth through 1989 and by the growth through 1992 of the Federal Medicaid Assistance Percentage (FMAP), the differential share of each State's Medicaid program paid for by the Federal Government. A State's FMAP is an inverse function of its per capita personal income compared to the national average and is recalculated annually. The growing variance in the 1980s among State per capita incomes annually increased the average State FMAP through 1992. The 1992 rates are the highest since the early 1970s. However, revenue growth slowed dramatically for most States in 1990 and 1991 despite tax increases, and it is expected that 1993 will begin a process of annual FMAP decline for the majority of States.

In addition to the FMAP growth, however, the Medicaid growth was facilitated by what the *Wesser* paper describes as "expanding revenue sources" and what the *Hovey* paper terms "bootstrap financing." An increasing number of States began levying taxes on health providers to help

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provide the State share of Medicaid or accepting "voluntary contributions." While some of these systems resulted in a more equitable sharing of the Medicaid burden among providers, all resulted in increasing the amount of funds provided by the Federal Government without a similar burden on the State. In some States, this financing mechanism was accompanied by expansions of the definition of "disproportionate share" provider, a health provider with a high concentration of Medicaid and other poor patients.

Both the *Texas* and *Kentucky* papers describe the use of these mechanisms. Texas implemented a series of amendments to its disproportionate-share program that brought substantial amounts of new Federal funds into the State. Kentucky also used this mechanism. Both States supported these expansions through bootstrap financing, leveraging Federal dollars.

Virtually all the State papers describe an explosion of Medicaid costs that has just begun. Even without further benefit or eligibility expansions, most authors expect their States to experience major cost increases for the foreseeable future due to (1) health cost increases, (2) changing demographics, and (3) annual increases in utilization by groups recently made eligible. The State papers suggest that both the current structure of the program and expected increases for the future may well produce a major overhaul of the way health services are financed by governments in the 1990s. Given the dominance of Medicaid in the grant-in-aid system, it can be expected that any change will also constitute a reform of the system of intergovernmental finance.

Victor J. Miller



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## About the Authors

### National Papers

*Victor J. Miller* is Senior Fellow for Intergovernmental Finance at Federal Funds Information for States (FFIS), a joint service of the National Conference of State Legislatures and the National Governors' Association Center for Policy Research. Mr. Miller created FFIS in 1981. Prior to that, he served 2 years on the professional staff of the U.S. Senate Budget Committee and 6 years as fiscal economist with the U.S. Office of Management and Budget. He has written extensively on intergovernmental flows of funds.

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## **State Papers**

*Connecticut.* John R. Fadoir is a public management consultant with specialties in governmental budgeting and financial management, health and human services program analysis, and management systems development. He has more than 30 years' experience in the public sector, having served as both Budget Chief and Director of Fiscal and Program Policy for the Budget and Management Division of the Connecticut Office of Policy and Management. He has had broad experience in program analysis, budget formulation, and execution of all State health and human services program budgets and has written on a range of issues concerning budget policy, concepts, and process. He is a former President of the National Association of State Budget Officers.

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Budget Director (1983-86) and Secretary of Finance (1986-91) of the State of Delaware. He has also served as Director of Administration for the Delaware Department of Transportation.

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*Kentucky.* Merl M. Hackbart has been Professor of Finance and Public Administration at the University of Kentucky since 1984 and is currently serving as Assistant to the Chancellor, Lexington Campus, with special responsibility for providing coordination and leadership for the University's programmatic response to the Kentucky Education Reform Act of 1990. He has twice been Kentucky State Budget Director and has served in senior functions in the South Dakota State Planning Office and the Department of Transportation. He has written extensively on such subjects as the management of cash and debt in the public sector and on public budgeting.

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Administrator of the Budget and Management Division. He also has served as Assistant Administrator of Income Maintenance, Adult and Family Services, Oregon Department of Human Resources. He is a former President of the National Association of State Budget Officers.

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*Utah.* Dale C. Hatch is currently serving as Associate Commissioner for Budget and Finance for the Utah Higher Education State Board of Regents. He served as Director of the Utah Office of Planning and Budget for the period 1984-91 and is currently President of the National Association of State Budget Officers. Mr. Hatch has practiced as an attorney and CPA in Utah and Arizona, has served on the faculty of universities in both States, and is currently a member of the Governmental Accounting Standards Advisory Council.



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# **Federal and State Government Interactions: Implications for Medicaid**

Victor J. Miller  
Federal Funds Information for States

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## SUMMARY

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Substantial recent increases in State Medicaid spending have put strains on many States' budgets. These increases have been in response to new Federal mandates, to higher utilization, to increasing medical costs, and to States' electing additional benefit options. To date, these increases have been concentrated in States with low personal incomes that traditionally have provided lower levels of Medicaid services. These States have at least partially funded their shares of these increases by reducing spending for other programs, such as Aid to Families with Dependent Children (AFDC). The Federal Government should consider the impact on other programs when it enacts Medicaid legislation and should accompany any new mandates with incentives or offsets to mitigate negative consequences.



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# INTRODUCTION

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States perform an interactive fiscal function in our Federal system. Under current laws, most Federal funds for local governments flow through States, and State governments therefore translate Federal Government shifts into local government impacts. Most State governments will at least partially buffer local governments from Federal cutbacks.

Similarly, local governments—cities, counties, school districts—are creatures of the State. States have various levels and structures of local aid: for general government purposes, for education, etc. Demands placed on States are often borne at least partially by local government. Just as the Federal Government mandates State government behavior, States place similar requirements on local governments.

Local governments and private institutions provide most governmental services to the public. Their ability to do so is affected by their own revenue structures, as well as by Federal actions, by State reactions to Federal actions, and by independent State behaviors.

This paper will look at changes in Federal Government grants-in-aid over the past few decades (Part I), focus on particular sources of fiscal stress placed on State and local governments in the last decade (Part II), discuss the sources of differences in State Medicaid spending (Part III), and then summarize the impact of recent stress on State budgets.



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# HISTORY OF GRANTS

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In 1991, an estimated 11.3 percent of Federal spending consisted of "grants-in-aid to State and local governments." These grants varied widely in function, scope, structure, and purpose. They also were seen very differently by the different levels of government involved.

From the Federal perspective, grants-in-aid constitute spending "by the Federal Government in support of State and local programs of government operations or provision of service to the public." Grant programs include entitlements (primarily Medicaid, child nutrition, and Aid to Families with Dependent Children (AFDC)), block grants, shared revenues, in-kind grants, grants to Indian tribes, categorical formula grants, and discretionary grants. Excluded are Federal procurement of research services at State universities. Some grants support State programs, some local programs, some local programs under a State plan, and some private programs under a State or local government plan.

From the State perspective, however, these are often Federal programs that use State or local governments as delivery mechanisms and with which States have little choice but to comply. The differing perspectives produce very different conclusions as to (1) program objectives and (2) which government's objectives are driving the others.

In reality, grant programs generally support programs of shared interest between the Federal Government and other governments. In that sense, the Federal Government does not provide grants because it likes State and local governments, but rather because it wants these governments to share its interests and concerns and to work toward similar ends. And, in particular, it

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focuses on those governments that would not or could not perform the kind or degree of such work without Federal involvement.

## **Background**

Grants from the Federal Government to subnational governments actually predate the Constitution, and the perspective of the Federal Government has changed as perceptions of intergovernmental structures have changed. The Administration of Andrew Jackson, trying to distribute an unexpected Federal surplus among the States, wondered about the constitutionality of such grants and finally decided to distribute the funds as loans (with no conditions for repayment).

As the scope of the Federal Government slowly grew, further grant appropriations for small highway or education projects were enacted. The development of today's structure of grants-in-aid is generally traced back to the passage in 1862 of the first Morrill Act. That Act authorized grants of Federal lands to the States, which could then raise resources for institutions of higher education by selling these tracts. The Act established three conditions that still govern Federal grants-in-aid:

**National Purpose.** The land grant colleges were to educate the young in "agricultural and mechanical arts" and, given Civil War-related needs, to provide military instruction.

**Financial Accountability.** States were to invest proceeds of the sales in approved securities.

**Output.** The States specifically were to provide for instruction.

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However, many provisions that might accompany a modern grant-in-aid program were missing—matching requirements, program plans, cost allocation plans, audits, etc.

In 1887, the Hatch Act provided for the first annual grants to States for agricultural experiment stations. States were required to submit annual reports to the U.S. Secretary of the Treasury, and soon thereafter Congress authorized the Secretary of Agriculture to conduct audits. Other early grants provided assistance for State Veterans' homes and forestry programs.

The Smith-Lever Act (1914) established the first formula grant in support of State agricultural extension programs, and the Smith-Hughes Act (1917), supporting vocational education, required detailed planning and administrative requirements. The first truly large-scale assistance program was enacted in 1916 in the form of Federal aid for State highway construction. This was followed by the Vocational Rehabilitation Act of 1920, to help disabled veterans, and the Sheppard-Towner (Maternity) Act of 1921, aimed at decreasing maternal and infant mortality. These latter Acts placed the Federal Government squarely in the field of grants supporting human services programs. The challenge to the constitutionality of the Sheppard-Towner Act and the refusal of the U.S. Supreme Court to grant standing to the State of Massachusetts paved the way for an expansion of Federal grant activity. By the early 1920s, Federal grants for highway construction exceeded \$90 million each year, with other grants totaling about \$26 million.

## **Emergency Relief**

The amount of Federal grant-in-aid activity was broadened and deepened with the Great Depression. Billions of dollars in "emergency relief"

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supported highway, road, and bridge construction, emergency work relief, and emergency expenditures for public bodies. In the peak year of 1935, an astounding total of \$2.2 billion (or one-third of Federal expenditures) was spent through these programs. Although these programs all terminated as World War II began, they did establish two precedents: (1) the allocation of funds among States on the basis of fiscal capacity and financial burden and (2) the use of Federal grants as part of a program to stimulate the economy.

A further impact of the Depression was the expansion of direct contacts between the Federal Government and local governments. The Depression left many cities with large unemployed populations and tax delinquencies, and cities banded together successfully to lobby the Federal Government for direct aid. It was during this period that the Federal-local program for public housing was established.

Perhaps the most lasting impact of the Depression on the grant-in-aid system was created by the passage of the Social Security Act of 1935. The Act established many programs whose legislative descendants still provide assistance—programs for old-age assistance, aid to the blind, aid to dependent children, unemployment compensation, maternal and child health, crippled children, and child welfare. These programs were large in scope and had substantially larger planning requirements and Federal oversight. By World War II, grants for social welfare exceeded construction grants.

## **Post World War II**

After World War II, new urban-oriented programs continued to be established, including airport construction (1946), urban renewal (1949), and urban planning (1954). However, the most significant grant-in-aid event of the 1950s was the passage of the Highway Act of 1956, which established

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the Interstate Highway System. The Act established the Highway Trust Fund, and the expenditure of \$953 million in 1957 constituted the first major trust fund expenditure for grants.<sup>1</sup> Most new programs of this decade were oriented toward capital investment, and by the 1960s grants for construction once again exceeded those for individuals.

The grant system continued to grow in the 1960s, as governments at all levels supported increased governmental presences in new substantive areas and as conclusions were reached that the Federal Government's tax and administrative systems were more appropriate for many programs. The most important grant-in-aid event of the decade was the addition of Title XIX (Medicaid) to the Social Security Act. A second major event of the 1960s was the passage of the Elementary and Secondary Education Act, which for the first time provided substantial Federal resources to help local school districts educate the poor. Overall, the Johnson Administration presided over what the Advisory Commission on Intergovernmental Relations (ACIR) termed an "explosion" in categorical grants. The 1967 ACIR study, *Fiscal Balance in the American Federal System*, described the following changes:

- a proliferation of grants;
- an expanded use of project grants;
- an increased variety of matching ratios;
- the development of incentive grants;

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<sup>1</sup>Even today, virtually all Federal Government grants-in-aid from trust funds are made for transportation purposes. However, "special funds," similar to trust funds, receive receipts from a variety of sources and are the source of intergovernment grant-in-aid flows.

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- the development of multifunctional grants;
  - a diversification of eligible grant recipients;
  - increasing grants to urban areas;
  - inflexibility of administrative and fiscal requirements;
  - an expansion of planning requirements; and
  - variation in regional office structures.

The ACIR counted 160 grant authorizations in 1962 and 379 in 1966. Most of the increases were for discretionary project grants. Perhaps most significant, grants began bypassing both State and local governments to newly created community action agencies. In its War on Poverty, thus, the Federal Government began creating its own quasi-governments. In addition, multifaceted grants with multiple objectives became more prevalent, as the Federal Government attempted programmatically broad attempts to help depressed areas (e.g., model cities, Appalachian regional development) or given clienteles (e.g., Juvenile Delinquency and Youth Offenses Control Act, Older Americans Act, Economic Opportunity Act). This expansion and diversification of programs was accompanied by an extraordinary increase in State and area planning requirements, and many new Federal grants were specifically aimed at underwriting the costs of State bureaucracies to write those plans.

It is important to note a shift in emphasis that began to occur during this period. While previous grant proposals had resulted from interest at the State and local levels, by the 1960s the Federal Government itself became the

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driving force behind establishing and expanding the system. This activism was founded on two premises: (1) that a number of States either could not or would not provide needed services to the poor and to cities and (2) that the extraordinary revenue-producing capacity of the Federal income tax was producing a "fiscal drag" on the economy.

A reaction to this proliferation set in by the 1970s. The Nixon Administration, complaining about "overlapping and duplicative" categorical grants, proposed six "special revenue sharing" programs that would replace a myriad of categorical programs. Three of these proposals received some support in Congress, resulting in the enactment of Community Development Block Grants (CDBG) and the Comprehensive Employment and Training Act (CETA) and amendments to Law Enforcement Assistance Administration (LEAA) programs. In addition, the Administration gave its strong support to the idea of general revenue sharing to assist State and local governments while reducing fiscal drag, and the program was enacted in 1972. The Administration also proposed substantial amendments to the AFDC and Medicaid programs, although the reforms proposed were not seriously entertained by the Congress. The massive growth in grants for education, employment and training, and fiscal assistance shifted the focus of grant spending, with grants for individuals growing more slowly and grants for capital investment shrinking in importance.

Despite its complaints about grant structure, the Nixon Administration did not initially step back from its financial commitment to the system. However, faced with deficits exceeding \$20 billion and the ongoing enactment of additional budget authority by the Congress, the Administration began to administratively impound substantial funds, primarily grants for wastewater treatment and for highway construction. It justified these impoundments on the basis of fiscal policy. Congress, frustrated over its

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lack of control, passed the Congressional Budget and Impoundment Control Act of 1974. This Act gave Congress the mechanism to establish its own fiscal policy, gave it an independent source of budget data and analysis (the Congressional Budget Office), and required the Executive Branch to ask for permission not to spend appropriated funds.

Congress rejected the Administration's proposals to defer spending for the grant programs,<sup>2</sup> and the commitment to increased spending for grants continued through the Ford and into the Carter Administrations. As a result, spending for grants continued to double every 5 years, from \$15 billion in 1967 to \$34 billion in 1972 to \$68 billion in 1977. As a share of total Federal spending, grants grew from under 10 percent in 1967 to 15 percent in 1972 to 17 percent in 1977.

In the second half of the 1970s, the focus of Federal aid shifted toward the Depression-era concept of stimulating the economy through grants to local governments. First in the Ford Administration, and then at the beginning of the Carter Administration, billions of dollars were appropriated for CETA public sector employment, local public works construction of the Economic Development Administration (EDA), and anti-recession fiscal assistance (ARFA). In the period 1976-79, almost \$22 billion was appropriated for these programs, most of which went directly to local governments, bypassing States.

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<sup>2</sup>Although today's "obligation limitation" of Federal-Aid Highways funds can be traced to the perceived need to limit these grants through a mechanism outside the impoundment control process.

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## The Decade of Retrenchment

By 1979, the Carter Administration saw potential deficits approaching \$100 billion and was faced with a newly skeptical Congress doubtful about the return from this outpouring of grants. As a result, no additional funds were appropriated for ARFA or the EDA local public works program, grants for wastewater treatment and public service employment were cut back, and funding for the State share of general revenue sharing was terminated. This dramatic increase and decline in grant funding proved a watershed, and the subsequent Reagan Administration acted to continue these already substantial reductions.

The Reagan Administration saw four major focuses in grants: a continued stepping back from the direct relationships with local governments, a merging of smaller categorical grants into block grants, increased funding for transportation grants, and the onset of Medicaid's growth. In addition, continued uncertainties in timing and levels of Federal appropriations for grants created substantial annual planning problems for State and local governments.

The passage of the Omnibus Budget Reconciliation Act of 1981 (OBRA) dramatically restructured the grant-in-aid universe. New health, education, and community services block grants to the States replaced categorical grants to State and local governments at severely reduced authorizations. Eligibility for income support programs was restricted, and financial reimbursements to States for Medicaid were reduced for the 1982-84 period. Many existing programs saw their authorization levels reduced.

Subsequently, the passage of the Job Training Partnership Act (JTPA) eliminated public service employment as a federally subsidized activity and

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for the first time placed a significant emphasis on governors as decisionmakers vis-à-vis Federal training grants. Later, general revenue sharing was terminated, with complaints about its payments to all jurisdictions regardless of need. Appropriations for community development grants were severely cut back, and wastewater treatment grants saw both reductions in funding and a restructuring from local grants into State revolving funds. As a result of these and other shifts, budget authority for grants dropped more than 13 percent in 1982.

The severe recession in 1982 provided an excuse for replacing part of the appropriations lost in 1982. Approximately \$4 billion in grant funds were allocated through the 1983 emergency jobs bill supplemental, of which \$1 billion flowed through the Community Development Block Grant program. Unlike previous efforts at economic stimulation, however, funds were disbursed through a wide variety of primarily preexisting programs.

Tables 1 and 2 illustrate both the overall decline and change in composition of Federal grants in the period 1977-87. Grants outlays declined from 17 percent of Federal outlays in 1977 to 11 percent.<sup>3</sup> Excluding Medicaid, this decline was even more pronounced, falling from 14 percent in 1977 to 8 percent in 1987.

The Reagan Administration initially placed a major emphasis on increasing transportation grants. It supported raising the tax on gasoline to 9 cents per gallon from 4 cents, with 1 cent of the increase to be used for major mass transit construction. This resulted in a significant increase in funds flowing into the Highway Trust Fund beginning in 1983. Budget authority for

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<sup>3</sup>This may be compared to grant budget authority, which dropped from a peak of 19.4 percent in 1977 to 14.1 percent in 1981, 11.3 percent in 1982, and 10.2 percent in 1987.

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**Table 1**  
**Functional History of Federal Grants-in-Aid, 1977-91**  
**(Federal fiscal years; outlays in millions)**

	1977	1979	1981	1983
National Defense	\$96	\$94	\$75	\$86
Energy	74	183	617	482
Natural Resources & Environment	4,189	4,631	4,944	4,018
Agriculture	371	456	829	1,822
Commerce & Housing Credit	8	12	4	62
Transportation	8,299	10,438	13,462	13,248
Community & Regional Development	4,496	6,641	6,124	4,962
Education, Trng., Employ., & Soc. Svcs.	15,753	22,249	21,474	16,125
Health	12,104	14,377	18,895	20,224
Income Security	12,663	14,740	21,013	24,758
Veterans Benefits & Services	79	86	74	66
Administration of Justice	713	517	332	101
General Government	9,571	8,434	6,918	6,541
Total	68,415	82,858	94,762	92,495
As Percentage of federal budget:				
Total	16.72%	16.46%	13.97%	11.44%
Without medicaid	14.31%	13.99%	11.49%	9.09%

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 1 (continued)**  
**Functional History of Federal Grants-In-Aid, 1977-91**  
**(Federal fiscal years; outlays in millions)**

	1985	1987	1989	1991
National Defense	\$157	\$193	\$253	\$304
Energy	529	455	420	451
Natural Resources & Environment	4,069	4,073	3,606	3,980
Agriculture	2,420	2,092	1,359	1,369
Commerce & Housing Credit	2	1	0	0
Transportation	17,055	16,919	18,225	19,818
Community & Regional Development	5,221	4,235	4,074	4,793
Education, Trng., Employ., & Soc. Svcs.	17,817	18,657	21,987	26,832
Health	24,451	29,466	36,679	54,892
Income Security	27,153	29,972	32,523	42,745
Veterans Benefits & Services	91	95	127	152
Administration of Justice	95	288	520	928
General Government	6,838	2,000	2,204	2,307
Total	105,897	108,446	121,976	158,572

As Percentage of federal budget:

Total	11.19%	10.80%	10.66%	11.25%
Without medicaid	8.80%	7.88%	7.46%	7.36%

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 1a**  
**Functional History of Federal Grants-in-Aid, 1977-91**  
**(Federal fiscal years; % change)**

	1977-87	1987-89	1989-91
National Defense	101.04	31.09	20.16
Energy	514.86	-7.69	7.38
Natural Resources & Environment	-2.77	-11.47	10.37
Agriculture	463.88	-35.04	0.74
Commerce & Housing Credit	-87.50	-100.00	N/A
Transportation	103.87	7.72	8.74
Community & Regional Development	-5.81	-3.80	17.65
Education, Trng., Employ., & Soc. Svcs.	18.43	17.85	22.04
Health	143.44	24.48	49.66
Income Security	136.69	8.51	31.43
Veterans Benefits & Services	20.25	33.68	19.69
Administration of Justice	-59.61	80.56	78.46
General Government	-79.10	10.20	4.67
Total	58.51	12.48	30.00
As Percentage of federal budget:			
Total	-35.38	-1.31	5.52
Without medicaid	-44.93	-5.26	-1.33

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 2**  
**Percent Distribution of Federal Grants-in-Aid, 1977-91**  
**(Federal fiscal years)**

	1977	1979	1981	1983
National Defense	0.14	0.11	0.08	0.09
Energy	0.11	0.22	0.65	0.52
Natural Resources & Environment	6.12	5.59	5.22	4.34
Agriculture	0.54	0.55	0.87	1.97
Commerce & Housing Credit	0.01	0.01	0.00	0.07
Transportation	12.13	12.60	14.21	14.32
Community & Regional Development	6.57	8.01	6.46	5.36
Education, Trng., Employ., & Soc. Svcs.	23.03	26.85	22.66	17.43
Health	17.69	17.35	19.94	21.86
Income Security	18.51	17.79	22.17	26.77
Veterans Benefits & Services	0.12	0.10	0.08	0.07
Administration of Justice	1.04	0.62	0.35	0.11
General Government	13.99	10.18	7.30	7.07
Total	100.00	100.00	100.00	100.00

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 2 (continued)**  
**Functional History of Federal Grants-in-Aid, 1977-91**  
**(Federal fiscal years)**

	1985	1987	1989	1991
National Defense	0.15	0.18	0.21	0.19
Energy	0.50	0.42	0.34	0.28
Natural Resources & Environment	3.84	3.76	2.96	2.51
Agriculture	2.29	1.93	1.11	0.86
Commerce & Housing Credit	0.00	0.00	0.00	0.00
Transportation	16.11	15.60	14.94	12.50
Community & Regional Development	4.93	3.91	3.34	3.02
Education, Trng., Employ., & Soc. Svcs.	16.82	17.20	18.03	16.92
Health	23.09	27.17	30.07	34.62
Income Security	25.64	27.64	26.66	26.96
Veterans Benefits & Services	0.09	0.09	0.10	0.10
Administration of Justice	0.09	0.27	0.43	0.59
General Government	6.46	1.84	1.81	1.45
Total	100.00	100.00	100.00	100.00

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 2a**  
**Percent Distribution of Federal Grants-in-Aid, 1977-91**  
**(Federal fiscal years)**

	1977-87	1987-89	1989-91
National Defense	26.83	16.55	-7.57
Energy	287.90	-17.93	-17.40
Natural Resources & Environment	-38.66	-21.29	-15.10
Agriculture	255.73	-42.24	-22.51
Commerce & Housing Credit	-92.11	-100.00	N/A
Transportation	-28.61	-4.23	-16.35
Community & Regional Development	-40.58	-14.47	-9.50
Education, Trng., Employ., & Soc. Svcs.	-25.28	4.78	-6.13
Health	53.58	10.67	15.12
Income Security	49.32	-3.53	1.10
Veterans Benefits & Services	-24.14	18.86	-7.94
Administration of Justice	-74.52	60.53	37.28
General Government	-86.82	-2.02	-19.48
Total	0.00	0.00	0.00

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

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transportation grants increased from \$12.8 billion in 1982 to \$18.5 billion in 1983 and \$20.2 billion in 1985. As shown in table 1, outlays also grew, though with a substantial lag. However, increasingly severe obligation limitations later in the decade withheld much of this authority from disbursement, building up balances in the Highway Trust Fund and slowing the increases in program outlays that might otherwise have been expected.

Continuing major budget deficits during the 1980s produced annual fights over budget cutbacks and subsequent uncertainties in Federal decisionmaking. Proposals to defer the use of grant funds under the impoundment control process were ultimately rejected, but planning by recipient governments was severely disrupted.<sup>4</sup> Passage of Federal appropriations occurred later each year, with short-term "continuing resolutions" resulting in the piecemeal allocation of grant funds. "Reconciliation bills," aimed at reconciling entitlement spending down to levels assumed in the annual budget resolutions, had their passage delayed, and State legislatures found their assumptions disrupted after adjournment. Passage of major tax reform legislation that affected both State receipts and practices was also delayed, with resulting planning problems for States.

## **Gramm-Rudman-Hollings and the Future**

The passage of Gramm-Rudman-Hollings (GRH) deficit reduction legislation had three major impacts on grant programs. First, it reduced 1986 budget authority for grants by an estimated \$3 billion. Second, it produced greater uncertainties, as the bill was passed and implemented by the various grantmaking agencies, then declared unconstitutional, then reaffirmed in a

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<sup>4</sup>The deferral process was later declared unconstitutional by the Supreme Court.

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restructured format by the Congress. Third, GRH expressed congressional priorities in its exemptions and special rules. For example, monies sequestered from trust and special funds were not cancelled by a sequester, but remained in the funds to be used in future years. Even more importantly, needs-based entitlements such as Medicaid, AFDC, and child nutrition programs were totally exempted from GRH sequesters as Congress forced itself to address its long-term priorities.

These priorities have been reinforced in annual actions, since Congress has chosen to expand these needs-based programs despite budget constraints. Increases have been voted in such areas as nursing home reform, maternal and child health, Medicaid coverage of the elderly poor, spousal impoverishment, and nutrition aid for the homeless. Further increases are possible in the near future for nutrition assistance, welfare reform, and home health care.

Some of these expansions reflect Federal mandates unwanted and opposed by many States; others were generated by State interest and actions. This mix reflects the continuing shared interests of the different levels of government, though it seems clear that Federal interests increasingly drive the system. Recent court decisions have tended to break down lines in federalism, and Federal legislation and regulation have grown increasingly prescriptive.

Table 3 illustrates the continuing shifts in Federal grants. Payments for individuals grew from one-third of grants in 1977 to three-fifths in 1991 and will soon grow to two-thirds. Medicaid growth dominates, although income security and education grants have kept pace. Grants for capital investment are at a 15-year low, while all other grants continue their retreat.

**Table 3**  
**Composition of Grant-in-Aid Outlays, 1977-91**  
**(Federal fiscal years;)**

<b>Expenditures (dollars in millions)</b>				
	1977	1979	1981	1983
Payments for Individuals				
Medicaid	9,876	12,407	16,833	18,985
Income Security	11,514	13,535	19,257	22,543
Other	1,320	1,619	1,761	1,044
Major Capital Investment	16,164	20,061	22,149	20,510
Other Grants				
Education	5,309	6,940	7,774	6,724
Other	24,232	28,296	26,988	22,689
Total	68,415	82,858	94,762	92,495
<b>Percent Distribution</b>				
Payments for Individuals				
Medicaid	14.44	14.97	17.76	20.53
Income Security	16.83	16.34	20.32	24.37
Other	1.93	1.95	1.86	1.13
Capital Investment	23.63	24.21	23.37	22.17
Other Grants				
Education	7.76	8.38	8.20	7.27
Other	35.42	34.15	28.48	24.53
Total	100.00	100.00	100.00	100.00

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 3 (continued)**  
**Composition of Grant-In-Aid Outlays, 1977-91**  
**(Federal fiscal years)**

<b>Expenditures (dollars in millions)</b>				
	1985	1987	1989	1991
Payments for Individuals				
Medicaid	22,655	27,435	34,604	51,555
Income Security	24,999	28,409	30,805	40,004
Other	1,698	1,911	1,944	3,143
Major Capital Investment	24,875	23,843	24,542	26,922
Other Grants				
Education	7,960	8,693	10,256	12,783
Other	23,710	18,155	19,825	24,174
<b>Total</b>	<b>105,897</b>	<b>108,446</b>	<b>121,976</b>	<b>158,572</b>
<b>Percent Distribution</b>				
Payments for Individuals				
Medicaid	21.39	25.30	28.37	32.51
Income Security	23.61	26.20	25.25	25.23
Other	1.60	1.76	1.59	1.98
Capital Investment	23.49	21.99	20.12	16.98
Other Grants				
Education	7.52	8.02	8.41	8.06
Other	22.39	16.74	16.25	15.24
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

**Table 3a**  
**Composition of Grant-In-Aid Outlays, 1977-91**  
**(Federal fiscal years)**

	Percent Change		
	1977-87	1987-89	1989-91
Payments for Individuals			
Medicaid	177.79	26.13	48.99
Income Security	146.73	8.43	29.86
Other	44.77	1.73	61.21
Major Capital Investment	47.51	2.93	9.70
Other Grants			
Education	63.74	17.98	24.64
Other	-25.08	9.20	21.94
Total	58.51	12.48	30.00
Percent Distribution			
Payments for Individuals			
Medicaid	75.25	12.14	14.60
Income Security	55.66	-3.59	-0.11
Other	-8.67	-9.56	24.01
Capital Investment	-6.94	-8.49	-15.62
Other Grants			
Education	3.30	4.89	-4.13
Other	-52.73	-2.91	-6.20
Total	0.00	0.00	0.00

Note: All estimates are those of the 1992 President's budget. While 1991 spending for most programs will be similar to that shown above, it is now expected that 1991 Medicaid costs will be almost \$2 billion more.

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Passage in 1990 of the Budget Enforcement Act (BEA) partially slowed this trend. Under the BEA, major increases were provided in 1991 grant-in-aid discretionary budget authority, while expansions of entitlement programs were at least temporarily put on hold. However, long-term expansions already built into the Medicaid system continue to increase that program's costs without expansion, while growth in discretionary programs has slowed.

In 1986, the National Association of State Budget Officers (NASBO) adopted as policy a proposal to significantly increase Federal support for the needs-based entitlement programs and expressed a willingness to pay entirely for that presence with the elimination of a large number of Federal categorical grants. In that same year, the National Governors' Association (NGA) came close to endorsing a highway swap proposal. These and other actions indicate a clear dissatisfaction with the current system, although the direction of desired change is uncertain. Support or opposition for such proposals has hinged on (1) potential shifts in the flow of Federal funds among the different States and regions, (2) differences in philosophies as to what types of Federal structures are the more appropriate, (3) concern for the ability and willingness of the poorer States to provide certain of the services now supported with Federal aid, and (4) differing perceptions as to who benefits from the current system.

In sum, increases in grants for individuals and cutbacks elsewhere have begun a process of gradually reworking the universe of intergovernmental aid. There appears to be clear interest in a reordering of the Federal grant-in-aid structure, although it seems that this process will proceed gradually rather than through a major one-time shift.

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# FEDERAL STRESS ON STATE GOVERNMENTS

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It is difficult to measure State government fiscal burdens and stress and the possible implications for Federal action. In a global sense, States share the same tax base as the Federal Government—national wealth—although their ability to use it may be restricted. They have the ability to respond to economic shifts and program needs by adjusting their tax systems or spending plans. As such, the fiscal condition of a State government is at least partially the result of its own actions.

Nonetheless, economic conditions, Federal Government actions, and other events do create stress on State governments beyond their control, and those governments' abilities to handle that stress and serve their publics is of great interest to the Federal Government. The Federal Government needs to be aware of the impact of its decisions in one area on other areas of Federal interest.

The immediate nature of State fiscal stress is thus of less importance to the Federal Government than the impact of decisions resulting from that stress. Will budgetary actions by State and local governments exacerbate the impact of economic cycles? Almost certainly. Absent Federal resources, restrictions, or incentives, will such actions reduce services to a public increasingly in need of them? By definition, yes, as reduced revenues produce cutbacks in expenditures. The basic questions to be answered are:

- Are such actions of sufficient importance at any given time to warrant Federal intervention?



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- Can the Federal Government so structure its intergovernmental fiscal relationships to systematically minimize such effects?

It is possible to identify three major sources of financial stress placed on State governments from the grant-in-aid system in the 1980s: (1) the loss of true governmental aid, (2) the underfunding of block grants, and (3) the growth of the Medicaid program.

## **Elimination of Government Support Grants**

In the period 1979-81, a variety of Federal programs provided broad-based support to State and local governments. Some programs were designed specifically for this purpose, including general revenue sharing and Anti-Recession Fiscal Assistance (ARFA). Others performed this function as a secondary effect of their primary function. Thus, the local public works program of the Economic Development Administration was designed to stimulate a sluggish economy, as was the CETA countercyclical public service employment program. Both were instrumental in supporting the basic purposes of government, however, permitting recipient governments to provide services to the public in difficult periods. Other CETA programs, designed to provide training and employment to the poor, also served to help support the functions of State and local government.

As shown in table 4, these programs provided \$17.5 billion in 1979, \$15.2 billion in 1980, and \$12.0 billion in 1981. All of these programs have been terminated, and States and cities have been forced to make up the losses from own-source revenues or reduce services.



Table 4  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	Total			General Revenue Sharing			ARFA
	1979	1980	1981	1979	1980	1981	
Alabama	263	256	222	108	108	82	2
Alaska	59	51	36	22	22	16	0
Arizona	194	159	127	78	81	63	2
Arkansas	157	154	117	67	69	50	1
California	1992	1799	1288	774	794	570	11
Colorado	182	150	115	76	76	59	12
Connecticut	267	182	139	86	86	64	7
Delaware	58	52	40	21	21	16	0
District of Columbia	89	83	56	30	28	21	0
Florida	648	559	405	202	205	162	5
Georgia	377	316	239	150	151	116	3
Hawaii	79	74	47	34	32	24	0
Idaho	63	57	47	25	26	20	1
Illinois	805	726	594	343	339	254	25
Indiana	375	317	304	140	135	100	39
Iowa	158	140	122	82	86	65	2
Kansas	121	99	85	60	60	47	0
Kentucky	264	229	199	111	111	86	7
Louisiana	309	289	239	149	139	105	5

Table 4 (continued)  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	EDA Local Public Works			CETA		
	1979	1980	1981	1979	1980	1981
Alabama	14	1	0	139	147	139
Alaska	17	3	-1	20	26	21
Arizona	16	3	1	98	75	63
Arkansas	8	0	0	81	85	67
California	201	62	15	1006	943	703
Colorado	9	0	0	84	74	56
Connecticut	43	8	1	130	89	73
Delaware	12	4	1	26	28	23
District of Columbia	11	8	2	48	47	33
Florida	66	18	2	374	336	241
Georgia	29	6	1	194	159	122
Hawaii	10	3	2	35	39	22
Idaho	8	1	0	29	31	26
Illinois	46	14	1	392	373	339
Indiana	14	2	1	182	180	204
Iowa	10	0	0	65	53	56
Kansas	9	2	2	52	37	36
Kentucky	13	3	0	132	116	113
Louisiana	12	1	1	144	149	133

Table 4 (continued)  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	Total			General Revenue Sharing			ARFA
	1979	1980	1981	1979	1980	1981	
Maine	108	83	71	45	41	30	4
Maryland	330	283	234	137	134	100	31
Massachusetts	556	472	315	219	215	163	4
Michigan	824	735	652	287	293	219	2
Minnesota	274	224	190	137	136	104	2
Mississippi	199	199	142	101	96	70	-6
Missouri	320	262	221	129	123	93	8
Montana	77	51	40	25	27	20	10
Nebraska	88	73	60	42	46	36	0
Nevada	30	38	30	17	17	14	-23
New Hampshire	60	42	30	23	23	17	0
New Jersey	719	604	432	224	226	171	19
New Mexico	103	82	73	44	41	32	0
New York	1885	1629	1220	769	751	549	22
North Carolina	376	309	259	170	169	128	0
North Dakota	45	35	25	17	20	14	0
Ohio	734	626	531	279	277	207	3
Oklahoma	162	139	110	73	76	59	0
Oregon	201	181	149	76	77	60	0

Table 4 (continued)  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	EDA Local Public Works			CETA		
	1979	1980	1981	1979	1980	1981
Maine	10	0	0	48	42	41
Maryland	21	4	2	141	146	132
Massachusetts	51	18	4	283	238	148
Michigan	116	30	8	420	412	424
Minnesota	14	2	0	121	86	86
Mississippi	8	0	0	95	102	72
Missouri	16	4	1	168	135	127
Montana	12	1	0	30	23	20
Nebraska	11	1	0	35	26	23
Nevada	9	2	0	27	18	16
New Hampshire	11	2	0	25	17	13
New Jersey	113	39	8	364	339	253
New Mexico	12	1	0	48	40	41
New York	265	61	15	830	818	657
North Carolina	20	3	1	186	137	129
North Dakota	11	2	0	17	14	11
Ohio	63	16	2	389	333	321
Oklahoma	12	4	1	77	59	50
Oregon	23	3	1	103	101	88

Table 4 (continued)  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	Total			General Revenue Sharing			ARFA	
	1979	1980	1981	1979	1980	1981	1979	1979
Pennsylvania	907	837	692	335	331	260	2	2
Rhode Island	90	77	58	29	29	23	0	0
South Carolina	223	183	144	92	91	71	6	6
South Dakota	49	36	30	22	23	18	0	0
Tennessee	291	275	229	126	130	97	2	2
Texas	748	656	518	337	331	247	0	0
Utah	84	69	57	41	43	34	0	0
Vermont	53	36	27	20	21	16	1	1
Virginia	326	292	224	142	141	107	9	9
Washington	297	260	217	96	94	75	4	4
West Virginia	144	130	122	63	61	47	0	0
Wisconsin	314	278	228	159	160	119	1	1
Wyoming	30	23	17	13	14	11	0	0
Puerto Rico	332	296	225	0	0	0	0	0
Territories	28	23	17	0	0	0	0	0
United States	17,473	15,231	12,011	6,847	6,829	5,134	227	227

Table 4 (continued)  
Grants-in-Aid Providing Broad-Based Support to State and Local Governments in 1979-81  
(\$ in millions)

State	EDA Local Public Works			CETA		
	1979	1980	1981	1979	1980	1981
Pennsylvania	87	17	4	483	488	428
Rhode Island	16	6	2	45	42	34
South Carolina	9	1	0	115	90	73
South Dakota	12	1	0	14	12	12
Tennessee	12	2	1	151	142	131
Texas	33	9	1	378	316	271
Utah	9	3	1	34	23	23
Vermont	11	1	0	20	15	11
Virginia	20	3	0	156	148	116
Washington	33	6	1	163	159	142
West Virginia	12	2	1	68	67	74
Wisconsin	12	1	0	142	117	109
Wyoming	10	2	0	8	7	6
Puerto Rico	83	13	5	249	283	220
Territories	10	6	2	18	17	15
United States	1,717	404	90	8,683	7,999	6,786

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## Underfunding of Block Grants

Block grants generally have a series of Federal purposes and are usually designed so that the administering government can choose among the purposes. Most block grants currently go to or through State governments, and some flow directly to local governments. Often these multiple purposes reflect the purposes of the program that were merged into the block. To many, the concept of a block grant is as much the process of creating the program—a blocking up of former categorical grants—as the final product.

In addition, block grants administered by the Department of Health and Human Services permit a State to obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds. This essentially incorporates each State's laws and regulations into Federal law, rather than centrally dictating one structure.

Finally, some block grants permit a portion of funds to be transferred to another purpose (e.g., Low Income Home Energy Assistance Program [LIHEAP], Social Services Block Grant), or set-asides within a block grant may be adjusted (e.g., alcohol, drug abuse, mental health services).

Table 5 illustrates the slow growth in block grant spending in the period 1987-91. While the 11 programs shown in table 5 grew 12.2 percent, virtually all the growth was for the three high-profile anti-drug-abuse programs.

In addition to slow growth, some of these programs received additional set-asides. Most of the increase for the alcohol, drug abuse, and mental health services block grant was reserved specifically for substance abuse, and a number of rural States found that the new set-aside for intravenous drug



Table 5  
 Appropriations for Major Block Grants, 1987-92  
 (Federal fiscal years; outlays in millions)

	1987	1988	1989	1990	1991
Drug Control & System Improvement	\$225	\$70	\$150	\$447	\$475
Drug-free Schools & Communities	161	191	288	438	498
Alcohol, Drug Abuse, & Mental Health	509	487	806	1,193	1,269
Subtotal, Drug Abuse	895	748	1,244	2,078	2,242
Low Income Home Energy Assistance	1,822	1,532	1,383	1,443	1,610
Social Services	2,700	2,700	2,700	2,800	2,800
Job Training	1,840	1,809	1,788	1,745	1,778
Maternal & Child Health	497	527	554	554	587
Preventive Health	90	86	85	84	93
Education Chapter 2	500	479	463	456	449
Community Development	3,000	2,880	2,650	2,915	3,200
Community Services	335	326	319	323	349
Subtotal, Other Programs	10,784	10,339	9,942	10,320	10,866
Total	\$11,679	\$11,087	\$11,186	\$12,398	\$13,108

Note: Only includes programs in existence since 1987.

Table 5 (continued)  
 Appropriations For Major Block Grants, 1987-92  
 (Federal fiscal years; outlays in millions)

	1992 Budget	1992 Approp.	Change 1987-92	% Change	
				1987-91	1991-92
Drug Control & System Improvement	\$462	\$475	\$250	111.1	0.0
Drug-free Schools & Communities	498	508	347	209.3	2.0
Alcohol, Drug Abuse, & Mental Health	1,269	1,360	851	149.3	7.2
Subtotal, Drug Abuse	2,229	2,343	1,448	150.5	4.5
Low Income Home Energy Assistance	1,025	1,500	(\$322)	-11.6	-6.8
Social Services	2,800	2,800	100	3.7	0.0
Job Training	1,778	1,773	(\$67)	-3.4	-0.3
Maternal & Child Health	554	650	153	18.1	10.7
Preventive Health	108	135	45	3.3	45.2
Education Chapter 2	449	450	(\$50)	-10.2	0.2
Community Development	2,920	3,400	400	6.7	6.3
Community Services	0	360	25	4.2	3.2
Subtotal, Other Programs	9,634	11,068	284	0.8	1.9
Total	\$11,863	\$13,411	\$1,732	12.2	2.3

Note: Only includes programs in existence since 1987.

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abuse resulted in a shifting of funds away from their higher priority programs combating alcohol abuse.

Over the past 5 years, State governments have thus found themselves diverting own-source revenues to make up for the costs of inflation and set-asides in programs financed through block grants. This process can be expected in the future. On net, appropriations for these 11 block grants grew 2.3 percent in 1992, approximately the same rate as the preceding 5-year average.

## **Growth in Medicaid**

The most important source of budgetary strain has come from the dramatic growth of the Medicaid program. States provide 43 percent of Medicaid funds from own-source revenues, and the growth in Federal grants has been accompanied by a growth in funds States have had to supply.

As shown in table 6, State 1979 own-source spending for Medicaid was only \$9.7 billion. By 1981, this had grown to \$13.3 billion. In 1991, State own-source spending is estimated to total \$40 billion, an increase of \$26.7 billion (200 percent) over 10 years.

This decade-long explosion, averaging more than 14 percent per year, comes from a variety of factors, including (1) increases in costs, (2) expansions of technology, (3) increased utilization, (4), Federal mandates, (5) increased options and States' utilization of those options, and (6) court decisions.

Like the block grants, the expansion of the program has been driven by a Federal Government increasingly determined to define the parameters of the

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Table 6  
State Own-Source Spending for Medicaid, Selected Years  
(Federal fiscal years; dollars in millions)

State	1979	1980	1981	1990	1991	Increase 1981-91	% Increase 1991/81
United States	\$9,702	\$11,234	\$13,290	\$31,328	\$39,995	\$26,704	198.5
New England	770	870	959	2,721	3,778	2,819	293.9
Connecticut	154	175	197	616	783	587	298.3
Maine	40	47	52	153	219	167	320.3
Massachusetts	475	531	572	1,565	2,212	1,640	286.8
New Hampshire	24	30	34	118	198	163	473.4
Rhode island	60	67	80	204	283	204	255.4
Vermont	18	20	24	64	83	58	240.3
Mideast	3,040	3,549	4,136	9,711	12,561	8,425	203.7
Delaware	20	23	28	65	95	67	238.8
District of Columbia	74	89	84	221	241	157	187.1
Maryland	175	223	248	626	769	520	209.5
New Jersey	354	375	432	1,224	1,620	1,188	275.4
New York	1,884	2,260	2,646	6,211	7,830	5,184	195.9
Pennsylvania	532	580	698	1,363	2,007	1,309	187.5

Table 6 (continued)  
State Own-Source Spending for Medicaid, Selected Years  
(Federal fiscal years; dollars in millions)

State	1979	1980	1981	1990	1991	Increase 1981-91	% Increase 1991/81
Great Lakes	\$1,792	\$2,108	\$2,516	\$5,056	\$5,946	\$3,430	136.3
Illinois	495	639	764	1,267	1,390	627	82.1
Indiana	141	169	199	541	682	483	242.3
Michigan	569	604	707	1,273	1,604	896	126.7
Ohio	319	384	488	1,355	1,543	1,055	216.2
Wisconsin	267	312	358	620	726	369	103.2
Plains	598	682	804	1,844	2,369	1,565	194.7
Iowa	102	106	124	250	299	175	141.0
Kansas	85	93	107	240	284	178	166.5
Minnesota	226	271	311	707	839	527	169.4
Missouri	97	124	157	402	663	505	321.5
Nebraska	47	49	57	130	156	100	176.0
North Dakota	22	20	25	65	71	46	183.6
South Dakota	19	19	23	50	57	34	147.8

Table 6 (continued)  
State Own-Source Spending for Medicaid, Selected Years  
(Federal fiscal years; dollars in millions)

State	1979	1980	1981	1990	1991	Increase 1981-91	% Increase 1991/81
Southeast	\$1,133	\$1,353	\$1,552	\$4,822	\$6,516	\$4,964	319.9
Alabama	68	91	88	223	306	218	248.4
Arkansas	59	69	80	166	195	115	144.4
Florida	169	176	220	1,177	1,563	1,344	611.7
Georgia	145	166	192	605	788	596	309.8
Kentucky	84	106	125	287	414	289	230.9
Louisiana	107	136	143	396	563	420	293.9
Mississippi	49	55	61	132	172	111	181.8
North Carolina	122	148	170	508	720	550	323.0
South Carolina	59	81	92	245	364	272	296.5
Tennessee	106	122	138	438	625	487	352.3
Virginia	135	163	198	543	662	464	234.9
West Virginia	31	38	46	102	145	99	217.4



Table 6 (continued)  
State Own-Source Spending for Medicaid, Selected Years  
(Federal fiscal years; dollars in millions)

State	1979	1980	1981	1990	1991	Increase 1981-91	% Increase 1991/81
Southwest	\$507	\$566	\$703	\$1,740	\$2,273	\$1,571	223.6
Arizona	0	0	0	241	317	317	n/a
New Mexico	19	24	30	85	102	71	236.4
Oklahoma	98	108	142	254	281	138	97.0
Texas	390	433	530	1,160	1,574	1,044	197.1
Rocky Mountains	150	166	200	473	624	424	282.5
Colorado	79	90	104	271	368	264	252.4
Idaho	18	19	22	47	62	40	183.0
Montana	23	24	33	56	67	34	104.2
Utah	25	25	32	76	93	61	192.6
Wyoming	6	8	9	24	34	25	282.2

Table 6 (continued)  
State Own-Source Spending for Medicaid, Selected Years  
(Federal fiscal years; dollars in millions)

State	1979	1980	1981	1990	1991	Increase 1981-91	% Increase 1991/81
Far West	\$1,617	\$1,826	\$2,292	\$4,710	\$5,618	\$3,325	145.1
California	1,369	1,523	1,945	3,810	4,523	2,578	132.5
Nevada	18	24	33	82	98	65	196.8
Oregon	77	89	96	225	284	189	197.0
Washington	153	191	219	592	713	494	226.3
Alaska	14	19	22	75	93	71	322.2
Hawaii	43	48	57	100	123	66	116.1
Puerto Rico	35	45	47	66	79	32	68.4
Territories	2	2	3	9	14	11	374.9

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program. Financing Federal Medicaid mandates was manageable for most States during the years of strong revenue growth in the 1980s. However, the current recession has produced substantial reductions in own-source revenues in most States, and Medicaid growth has choked off much spending that governors would consider of higher priority.

Unlike most economic downturns of the past 50 years, the Federal Government has chosen to ignore problems faced by State and local governments in providing services to the public. Worse, the expansion of the Medicaid program, the loss of block grant flexibility and funds, and the loss of true governmental aid have made it impossible for many governments to provide the levels of government services that their citizens expect.

The section that follows will provide data on selected differences among States and the differential impacts of the growth of the Medicaid program.

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## SOURCES OF VARIANCE IN STATE MEDICAID SPENDING

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State Medicaid programs and costs vary significantly in response to such variables as the demographic composition of a State, its wealth, the availability of services, the share of costs provided by the Federal Government, and a State's preferences for (1) governmental provision of services and (2) health services in general.

Federal Medicaid expansions affect State programs in two ways. First, expansions in options available to States will increase spending differentially among States based on all of the above characteristics. Some States with low preferences for governmental expenditure in general may adopt a specific form of option. This happened recently in many southeastern States with the expansions of Medicaid coverage for maternal and child health. Other States with high preferences for governmental services may not elect expansions in an area where they have large potential clienteles or costs, or in a time of fiscal stress. New York's decision not to initiate the welfare reform JOBS program in 1989 is an example where current fiscal conditions affect at least the timing of programmatic decisions.

Expansions in mandates have a very different impact on States, since only demographic characteristics and the availability of services will affect the level of program. The mandate has no impact on a State that already provides such a Medicaid service while providing fiscal relief to States that provide benefits on a State-only basis. For most States, however, mandates expand programs, and a State can affect the initial costs of a mandate primarily by how aggressively it markets the new service and to what extent it reimburses providers.

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This section looks at the differential impacts of some of the characteristics mentioned above on new Medicaid options and mandates.

## Demographics

A State's demographic structure will affect strongly both its willingness and ability to pay for new services. Most Medicaid services are provided to individuals outside the work force. States with high shares of such populations therefore have fewer persons inside the work force to create the wealth that pays for Medicaid services.

In addition, eligibility for Medicaid services is either a function of relationship to a Federal poverty line or eligibility for a Federal welfare program (AFDC, SSI). The latter also is a function of relationship to that same poverty line. Since the cost of living is much lower in some States (e.g., Alabama) than others (e.g., New York), a much higher share of persons in Alabama become Medicaid eligible when eligibility is a function of that line.

Table 7 compares the Census Bureau's 1980 and 1990 data on poverty by State.<sup>5</sup> As can be seen, a Federal mandate based on a national poverty statistic requires a State such as Mississippi to cover four times the share of its population than States such as New Hampshire or Connecticut.

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<sup>5</sup>The 1990 data are from the March 1990 Current Population Survey, a sample not large enough to produce statistically significant counts. They are published by the Census Bureau for information purposes only and should be used with care.

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**Table 7**  
**Levels and Change in Poverty Population by State, 1980-90**  
**(numbers in thousands)**

State	1980		1990		Percent Change 1980-90	
	Number	Percent	Number	Percent	Number	Percent
Alabama	810	21.2	779	19.2	-3.8	-9.4
Alaska	36	9.6	57	11.4	58.3	18.8
Arizona	354	12.8	484	13.7	36.7	7.0
Arkansas	484	21.5	472	19.6	-2.5	-8.8
California	2,619	11.0	4,128	13.9	57.6	26.4
Colorado	247	8.6	461	13.7	86.6	59.3
Connecticut	255	8.3	196	6.0	-23.1	-27.7
Delaware	68	11.8	48	6.9	-29.4	-41.5
District of Columbia	131	20.9	120	21.1	-8.4	1.0
Florida	1,692	16.7	1,896	14.4	12.1	-13.8
Georgia	727	13.9	1,001	15.8	37.7	13.7
Hawaii	81	8.5	121	11.0	49.4	29.4
Idaho	138	14.7	157	14.9	13.8	1.4
Illinois	1,386	12.3	1,606	13.7	15.9	11.4
Indiana	645	11.8	714	13.0	10.7	10.2
Iowa	311	10.8	289	10.4	-7.1	-3.7
Kansas	215	8.4	259	10.3	20.5	22.6
Kentucky	701	19.3	628	17.3	-10.4	-10.4
Louisiana	868	20.3	952	23.6	9.7	16.3
Maine	158	14.6	162	13.1	2.5	-10.3
Maryland	389	9.5	468	9.9	20.3	4.2
Massachusetts	542	9.5	626	10.7	15.5	12.6
Michigan	1,194	12.9	1,315	14.3	10.1	10.9
Minnesota	342	8.7	524	12.0	53.2	37.9
Mississippi	591	24.3	684	25.7	15.7	5.8
Missouri	625	13.0	700	13.4	12.0	3.1
Montana	102	13.2	134	16.3	31.4	23.5
Nebraska	199	13.0	167	10.3	-16.1	-20.8
Nevada	70	8.3	119	9.8	70.0	18.1
New Hampshire	63	7.0	68	6.3	7.9	-10.0
New Jersey	659	9.0	711	9.2	7.9	2.2
New Mexico	268	20.6	319	20.9	19.0	1.5
New York	2,391	13.8	2,571	14.3	7.5	3.6
North Carolina	877	15.0	829	13.0	-5.5	-13.3
North Dakota	99	15.5	87	13.7	-12.1	-11.6
Ohio	1,046	9.8	1,256	11.5	20.1	17.3
Oklahoma	406	13.9	481	15.6	18.5	12.2
Oregon	309	11.5	267	9.2	-13.6	-20.0
Pennsylvania	1,142	9.8	1,328	11.0	16.3	12.2
Rhode Island	97	10.7	71	7.5	-26.8	-29.9
South Carolina	534	16.8	548	16.2	2.6	-3.6
South Dakota	127	18.8	93	13.3	-26.8	-29.3
Tennessee	884	19.6	833	16.9	-5.8	-13.8
Texas	2,247	15.7	2,684	15.9	19.4	1.3
Utah	148	10.0	143	8.2	-3.4	-18.0
Vermont	62	12.0	61	10.9	-1.6	-9.2
Virginia	647	12.4	705	11.1	9.0	-10.5
Washington	538	12.7	434	8.9	-19.3	-29.9
West Virginia	297	15.2	328	18.1	10.4	19.1
Wisconsin	403	8.5	448	9.3	11.2	9.4
Wyoming	49	10.4	51	11.0	4.1	5.8



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## Preferences

Relative preferences for governmental and health expenditures strongly drive the reactions of States to Medicaid expansions. Some States will adopt almost any new option. Others will eschew options in most areas but react positively and strongly to proposals in some.

Although all States by definition will adopt new mandates, their wealth and preferences will have a strong impact on how those new services are financed. States with high preferences might raise taxes or find ways of delaying payment. States with strong economies might use strong revenue growth to pay the bills.

By comparison, States with lower preferences or wealth might delay or defer other new services. Finally, States with low preferences and wealth will probably reduce other spending.

Historically, few States have raised broad-based taxes for the purposes of financing Medicaid. A strong drain on State funds may produce a tax increase, but it will usually be advertised as supporting education or another popular program. By the end of the fiscal cycle, however, it becomes clear that the purported beneficiary of the tax increase has received only a share of the proceeds.

Similarly, increases for Medicaid often do not produce what are seen as explicit tradeoffs. Governors underestimate the increased costs in their budgets, the legislature subsequently underfunds the program, and the system absorbs the increases during the fiscal year through supplemental appropriations and other adjustments. To the extent that the increases are funded, the offsets often come from limiting program growth. Given the

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appropriations structures of State legislatures, those offsets generally come from other large social programs such as public assistance. Over time, these freezes become significant cuts.

Table 8 displays data for the AFDC maximum benefits for a family of three over the past decade. In the relatively weak fiscal period of 1980-85, Medicaid growth was low and the median State AFDC increase of 15 percent was roughly half the level of inflation.<sup>6</sup> Medicaid growth accelerated in the second half of the decade, but relatively strong own-source revenue growth again resulted in a median AFDC growth half the rate of inflation. Only 17 States had increases above 2 percent in 1991, and the National Association of State Budget Officers reports that only 17 States have enacted any cost of living adjustment for fiscal year 1992.

These levels and increases can be compared to the levels of Federal supplemental security income (SSI) benefits over the same period.<sup>7</sup> A median State AFDC benefit that was 80 percent of the Federal SSI benefit in 1980 was down to 68 percent by 1985 and 60 percent in 1991. This trend can be expected to continue in the near future.

Preferences also determine how States respond to national eligibility criteria. A State with a preference for low government provision of services might complain that a national line requires greater coverage of its population by a Federal program. A high-government State with high costs also might complain that the national line unfairly restricts the share of its population it can cover.

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<sup>6</sup>As measured by the fixed-weight GNP price deflator.

<sup>7</sup>The SSI data in table 8 are for a couple in their own household. Approximately half the States supplement the Federal SSI benefits. Those supplements are not reflected here.

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**Table 8**  
**AFDC Maximum Benefit for a Three-Person Family, Selected Yrs**

State	7/80	1/85	1/87	1/88	1/90	1/91	% Change		
							1980-85	1985-90	1990-91
Alabama	\$118	\$118	\$118	\$118	\$118	\$124	0.0	5.1	5.1
Alaska	457	719	749	779	846	891	57.3	23.9	5.3
Arizona	202	233	293	293	293	293	15.3	25.8	0.0
Arkansas	161	164	192	202	204	204	1.9	24.4	0.0
California	473	555	617	633	594	694	17.3	25.0	16.8
Colorado	290	346	346	356	356	356	19.3	2.9	0.0
Connecticut	475	546	590	601	649	680	14.9	24.5	4.8
Delaware	266	287	310	319	333	338	7.9	17.8	1.5
District of Columbia	286	327	364	379	409	428	14.3	30.9	4.6
Florida	195	240	264	275	294	294	23.1	22.5	0.0
Georgia	164	208	256	263	273	280	26.8	34.6	2.6
Hawaii	468	468	468	515	602	632	0.0	35.0	5.0
Idaho	323	304	304	304	317	317	-5.9	4.3	0.0
Illinois	288	341	342	342	367	367	18.4	7.6	0.0
Indiana	255	256	256	288	288	288	0.4	12.5	0.0
Iowa	360	360	381	381	410	426	0.0	18.3	3.9
Kansas	345	373	403	409	409	409	8.1	9.7	0.0
Kentucky	188	197	197	207	228	228	4.8	15.7	0.0
Louisiana	152	190	190	190	190	190	25.0	0.0	0.0
Maine	280	370	405	416	453	453	32.1	22.4	0.0
Maryland	270	313	345	359	396	406	15.9	29.7	2.5
Massachusetts	379	396	491	510	539	539	4.5	36.1	0.0
Michigan (Wayne Co.)	425	468	473	513	516	525	10.1	12.2	1.7
Minnesota	417	524	532	532	532	532	25.7	1.5	0.0
Mississippi	96	96	120	120	120	120	0.0	25.0	0.0
Missouri	248	263	279	282	289	292	6.0	11.0	1.0
Montana	259	332	354	359	359	370	28.2	11.4	3.1
Nebraska	310	350	350	350	364	364	12.9	4.0	0.0
Nevada	262	233	285	325	330	330	-11.1	41.6	0.0
New Hampshire	346	378	397	486	506	516	9.2	36.5	2.0
New Jersey	360	385	404	424	424	424	6.9	10.1	0.0
New Mexico	220	258	258	264	264	310	17.3	20.2	17.4
New York (NYC)	394	474	497	539	577	577	20.3	21.7	0.0
North Carolina	192	223	259	266	272	272	16.1	22.0	0.0
North Dakota	334	371	371	371	386	401	11.1	8.1	3.9
Ohio	263	290	302	309	334	334	10.3	15.2	0.0
Oklahoma	282	282	310	310	325	341	0.0	20.9	4.9
Oregon	282	386	397	412	432	444	36.9	15.0	2.8
Pennsylvania	332	364	382	402	421	421	9.6	15.7	0.0
Rhode Island	340	479	503	503	543	554	40.9	15.7	2.0
South Carolina	129	187	199	200	206	210	45.0	12.3	1.9
South Dakota	321	329	366	366	377	385	2.5	17.0	2.1
Tennessee	122	138	155	159	184	195	13.1	41.3	6.0
Texas	116	167	184	184	184	184	44.0	10.2	0.0
Utah	360	363	376	376	387	402	0.8	10.7	3.9
Vermont	492	558	572	603	662	679	13.4	21.7	2.6
Virginia	310	327	354	354	354	354	5.5	8.3	0.0
Washington	458	476	492	492	501	531	3.9	11.6	6.0
West Virginia	206	206	249	249	249	249	0.0	20.9	0.0
Wisconsin	444	533	544	517	517	517	20.0	-3.0	0.0
Wyoming	315	360	360	360	360	360	14.3	0.0	0.0
Guam	261	265	265	265	330	330	1.5	24.5	0.0
Puerto Rico	44	90	90	90	90	90	104.5	0.0	0.0
Virgin Islands	209	171	171	171	240	240	-18.7	40.4	0.0
Median State	\$288	\$332	\$354	\$359	\$364	\$367	15.3	10.5	0.8
Federal SSI Benefit	357	488	510	532	579	610	36.7	25.0	5.4

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## Wealth

Virtually all studies to date have found State wealth (as measured by per capita income) to be a major determinant of State Medicaid choices. While high wealth also is correlated with geographic location and availability of medical services, it seems clear that tax wealth is at least one major determinant of State Medicaid spending.

It must be noted that wealth is not necessarily correlated with State fiscal health, for two reasons. First, economic cycles produce surges and shortfalls of revenues in a State whatever its underlying characteristics. Second, States projecting weak economies and declining revenue streams tend to be much more fiscally conservative than States enjoying stronger revenue growth. The former States may well enjoy a stronger fiscal condition in a given year than States initiating new programs based on stronger growth projections. Finally, fiscal health often is a function of long-term revenue and expenditure flows. Problems financing government in the current 1991 recession are not limited to the poorer States.

Table 9 shows the share of total income in each State that is devoted to Medicaid spending and the change since 1986. Most low-income States in the South and West have traditionally allocated a small share of that income to Medicaid. This is changing substantially. While States in the northeastern quadrant of the country still tend to devote a larger share of their incomes to Medicaid, the fastest growth is heavily concentrated in the four southern and western regions.

**Table 9**  
**Medicaid as a Share of Personal Income, 1986-90**

	Percent			% Change	
	1986	1989	1990	1986-90	1989-90
United States	1.24	1.39	1.57	26.6	12.8
Connecticut	1.14	1.35	1.58	38.4	17.1
Maine	1.80	1.87	2.21	22.7	18.2
Massachusetts	1.62	2.16	2.48	53.2	14.9
New Hampshire	0.82	0.88	1.04	27.0	18.6
Rhode Island	1.99	2.12	2.40	20.7	13.3
Vermont	1.30	1.40	1.66	27.2	18.5
Delaware	0.86	0.95	1.02	18.8	7.1
District of Columbia	2.79	2.71	3.05	9.6	12.6
Maryland	1.01	1.05	1.20	18.8	14.5
New Jersey	0.95	1.14	1.27	32.7	10.8
New York	2.84	2.94	3.21	12.9	9.3
Pennsylvania	1.29	1.36	1.40	9.0	3.0
Illinois	0.96	1.00	1.05	10.2	4.9
Indiana	1.28	1.41	1.67	30.3	18.6
Michigan	1.36	1.43	1.55	14.2	8.4
Ohio	1.43	1.59	1.78	24.4	12.3
Wisconsin	1.60	1.64	1.80	12.5	9.9
Iowa	1.02	1.25	1.42	38.8	13.7
Kansas	0.79	0.97	1.14	44.8	17.9
Minnesota	1.70	1.73	1.90	12.0	10.0
Missouri	0.88	1.02	1.12	28.0	9.6
Nebraska	0.93	1.10	1.24	33.6	13.1
North Dakota	2.11	2.01	2.13	1.0	5.6
South Dakota	1.29	1.53	1.60	23.6	4.5
Alabama	0.93	1.05	1.58	68.6	49.9
Arkansas	1.62	1.74	1.92	18.1	10.5
Florida	0.64	0.94	1.13	76.7	20.7
Georgia	1.05	1.29	1.50	43.2	16.9
Kentucky	1.38	1.71	1.94	40.8	14.0
Louisiana	1.64	2.05	2.45	50.0	19.9
Mississippi	1.36	1.70	2.01	48.6	18.4
North Carolina	1.00	1.24	1.45	44.2	16.5
South Carolina	1.13	1.31	1.86	65.6	42.9
Tennessee	1.36	1.64	1.99	46.2	20.8
Virginia	0.72	0.77	0.90	26.2	17.1
West Virginia	1.30	1.65	1.74	33.7	5.4



**Table 9 (continued)**  
**Medicaid as a Share of Personal Income, 1986-90**

	Percent			% Change	
	1986	1989	1990	1986-90	1989-90
Arizona	0.25	0.80	0.97	283.8	20.4
New Mexico	1.05	1.27	1.43	37.0	12.9
Oklahoma	1.22	1.49	1.55	27.4	4.3
Texas	0.75	0.93	1.18	57.6	26.8
Colorado	0.71	0.89	0.94	32.3	6.0
Idaho	0.75	0.95	1.09	45.2	14.2
Montana	1.31	1.53	1.69	28.5	9.9
Utah	0.99	1.00	1.22	23.3	22.7
Wyoming	0.54	0.80	1.07	98.0	33.2
California	1.04	1.07	1.17	12.3	9.3
Nevada	0.56	0.56	0.71	28.5	28.7
Oregon	0.80	1.00	1.16	44.0	15.4
Washington	1.04	1.25	1.42	35.9	13.2
Alaska	0.89	1.23	1.36	53.2	10.6
Hawaii	0.93	0.93	0.95	1.9	2.6

## Incentives

The Federal Government reimburses 50 percent of Medicaid services in wealthy States and 80 percent in the poorest States. Given State preferences and levels of wealth, the higher matching rates clearly have had some impact. Past research indicates that response has been small and that incentive effect has been relatively weak in the relevant range.

Recent events have changed the structure of incentives and have certainly contributed substantially to the growth of the program. The average Federal matching rate rose steadily throughout the 1980s, and the average matching rate in 1992 is at the highest rate since the early 1970s. As a result, most States expanding their Medicaid programs have undergone somewhat less



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stress than otherwise would have been the case.<sup>8</sup> "Bootstrap" financing<sup>9</sup> also accelerated in 1992, permitting States to expand their Medicaid programs at a smaller cost to general purpose revenues.

Thus, it is not surprising to see preferences met despite tight budgets. Complaints about Federal mandates notwithstanding, the majority of States have increased coverage of pregnant women and children beyond the minimums now mandated by Title XIX.<sup>10</sup> Despite revenue shortfalls during the recession, they have maintained these higher levels.

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<sup>8</sup>See Federal Funds Information for States (FFIS) Issue Brief 91-16 for further information. It is estimated that using the 1983 matching rates in 1993 would save the Federal Government almost \$2 billion in that year.

<sup>9</sup>Bootstrap financing refers to accepting voluntary contributions from health providers to help match Federal funds or taxing these providers for the same purpose. This generally results in providers' receiving higher net revenues, since the Federal funds provide for higher reimbursements or lower levels of uncompensated care.

<sup>10</sup>National Governors' Association data.

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## CONCLUDING OBSERVATIONS

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While virtually all States have exhibited substantial growth in Medicaid spending in recent years, Medicaid increases have been especially concentrated in States of the South and West. These States have traditionally provided lower levels of Medicaid services because of both (1) basic preferences and (2) smaller tax bases to support the higher levels of spending. They also have higher shares of their populations in families with incomes under the national poverty level. As a result, recently mandated services and coverages have resulted in disproportionate increases in these States.

Medicaid burdens on States have had a variety of impacts. In general, they have increased the Medicaid share of these States' budgets at the expense of other spending. In many cases, Medicaid expansions have been accompanied by low cost-of-living adjustments for the AFDC population. To the extent this is true, it represents an effective tax on one set of poor to increase benefits to another.

Medicaid spending is expected to continue to grow substantially even without further federally mandated expansions in coverage. This growth reflects expected accelerations in costs in the many States that have suppressed increases in reimbursement to providers and increased utilization of Medicaid services by populations newly made eligible. Such expenditure growth is expected to create major stresses on State finances as (1) the average match rate declines and (2) bootstrap financing is restricted. Once again, States in the South and West should continue to experience the largest share of the growth.

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The Federal budget process is designed to allow cost increases in Medicaid to proceed. While the Budget Enforcement Act may be expected to slow service and coverage expansions in the short run, there is nothing to suggest that the long-term bias of the Federal Government toward entitlement spending is about to end. At the same time, State budget processes permit the expansions, even with few explicit commitments to them.

State budget processes also tend to permit faster growth for Medicaid than for other programs. This reflects not only the entitlement nature of the program, but also strong lobbies of provider groups who promote both the program and levels of reimbursement. There are no such groups lobbying for other programs for the poor.

The Federal Government cannot expect increases in Medicaid spending to occur in isolation. Passage of Medicaid expansions should be accompanied by at least an understanding of how other State programs might be affected, especially during periods of recession. In particular, any future Federal mandates should be accompanied by increased Medicaid or AFDC incentives for the poorer States or with options that permit the States to make choices among currently mandated coverages.

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# **Who Pays When State Health Care Costs Rise?**

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# INTRODUCTION

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The escalation of health care costs continues to be felt by both State and local<sup>11</sup> governments in many differing capacities. First, these governments pay as employers. They have about 13 million workers covered by health insurance plans. Their plans usually offer family coverage, tend to be on the comprehensive side of average, and usually provide for employer payment of 75 to 100 percent of costs. Second, these governments pay for their wards, just as families would pay for children. The wards include inmates in prisons and youth offender facilities, mental health and mental retardation patients, and children in foster care and subsidized adoption.

Third, health care costs appear in other programs such as schools, vocational rehabilitation, and special programs to make welfare recipients ready for work and as a part of assistance provided the homeless. Fourth, these governments absorb health care costs built into the prices of goods and services they buy. Fifth, State and local governments are major health care providers themselves through (1) public health programs, (2) community hospital services offered in some areas, such as county hospitals in Georgia and Pennsylvania and State charity hospitals in Louisiana, and (3) State university hospitals which receive substantial subsidies through education budgets. Sixth, and most costly, they pay through the Medicaid program.

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<sup>11</sup>Why include local government? Because the two are essentially interchangeable. Patterns of responsibility are not the same among the States. For example, about half the States bear all Medicaid and court costs; almost half do not. Patterns can change as costs and resources shift. In 1991, California shifted substantial responsibility and resources to counties, but Pennsylvania picked up some local costs. Massachusetts sharply cut its sharing of local education costs, but Kentucky and Oklahoma were increasing theirs. Either States or local governments could solve their fiscal problems by shifting problems to the other level of government, but this conclusion is not helpful to policymakers.

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These health costs have been increasing sharply over the past several years, probably in the 12 to 20 percent range, although States do not keep track of health care costs in the aggregate. States have incurred the escalation in unit costs for services and the increasing consumption of services that have affected all health care consumers. In addition, States have been serving an increasing number of persons—particularly inmates, children who are State wards, and Medicaid recipients.

There are several hypotheses to explain who bears the burden of these increasing State health care costs. One is that the increase has come at the expense of the poor through more restrictive cash welfare assistance eligibility and lower levels of cash payments than would otherwise be the case. Another is that cost increases have resulted in higher State and local taxes than would have occurred otherwise. Another is that health's gains have been education's losses.

This paper examines these hypotheses. It is organized into five sections. First is an examination of competition in the State budget process, the institutional environment. Second is the fiscal environment. Various fiscal settings are defined, and those most relevant to this paper are identified. Third, these two environments are combined and the resulting combinations analyzed. The fourth section offers conclusions on the choices which the States face and how they seem to be exercising them. A final chapter addresses some of the broader issues associated with growing health costs, such as Federal and State roles and concern that emphasis on income-tested spending may deprive States of the voter support they need to raise taxes. There is an appendix dealing with the methodology of determining whether expansion of a government program is financed by tax increases or by curtailment of other programs and of which programs. Another appendix

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relates the current controversy over bootstrap financing to the issues discussed in the paper.

Readers inclined to start with conclusions should examine sections 4 and 5 first.

For the sake of simplicity and readability, several conventions are used in the report. "States" and "State governments" are used as a proxy for States and those local governments sharing in health care costs. Medicaid is used as a proxy for all relevant health costs. This is a reasonable simplification in dealing with health's contribution to fiscal pressures on State government. It is somewhat misleading in discussion of the circumstances where certain tradeoffs occur. Employee health benefits, for example, often compete with employee pay, while Medicaid may compete initially in the budget process with social service programs.



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# THE INSTITUTIONAL ENVIRONMENT

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## Introduction

There have been many studies of government budgeting in general and State budgeting in particular. They, and practical experience, show certain behavioral similarities among States. So do the results. That is, regardless of differences in budget processes, such as whether the budget is biennial or annual, the outcomes in terms of resource allocation are similar.

## Budgeting Is Incremental

The best single predictor of what a government will budget for a particular function for a particular year is what it budgeted for that function the previous year. This is not surprising. The decisionmaking group includes a heavy component of those who established the previous pattern. That pattern reflects the substantive views, public opinion climate, battles, and fact situations of a year previous, which is usually little changed.

The incremental nature of budgeting is so widely recognized that State budgeting procedures always adopt the current spending pattern as the basis for consideration of what to spend in the following year. In the nomenclature of budgeting, the spending in the current year becomes the basis for budgets for the budget year and, in the States with biennial budgets or budget projections, the base for the out year(s).

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## The Baseline Budget

State practices involve some concept of what is called the current service (or slightly different current policy) budget at the Federal level. This has different names such as the "baseline budget," the "standstill budget," the "current services budget," and even "the costs of opening the doors." The concept is to reflect the costs of carrying out current-year levels of activity adjusted for:

- Workload, the changes in numbers of welfare recipients, university students, license applicants, and the like;
- Scheduled cost changes, such as those associated with opening new prisons, phased-in benefit increases, and debt service payments;
- Mandates including Federal laws and regulations and court orders; and
- Uncontrollable price changes.

The definition of uncontrollable price changes varies considerably among States. Generally included are changes that are under the control of third parties, such as prices for office supplies and utility services. Usually also included are changes that have been incorporated into previously enacted State laws, such as changes in school aid formulas. Less often included at the State level are discretionary inflation adjustments such as those for pay increases for employees, grants to local governments, reimbursement rates for health care providers, and welfare cash assistance.

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## Health Care in the Baseline

How the baseline budget is defined is critically important to understanding how health care costs affect other categories of State spending and State taxing decisions. Being in the baseline creates a presumption of funding which other claimants for State resources may lack. In legislative and public perceptions, it makes it almost unnecessary to justify increases. Instead, the baseline redefines "cuts." So at the Federal level and in an increasing number of States, one seeking increases of 17 percent for Medicaid can be accused of cutting health care for the poor if the baseline budget contains an 18-percent increase.

Particularly important in the case of Medicaid is what is included in the baseline budget. Unlike many programs, its starting point is not last year's appropriation as approved by the legislature. Instead, it is the present estimate of what current year spending will be, including supplemental appropriations that may be contemplated. This gives Medicaid a substantial advantage over programs such as education, where supplemental appropriations are a minor factor.

## Competition Among Programs With Balanced Budgets

When resources available and baseline spending will balance with relatively minor adjustments, there often is no meaningful competition among the major budget categories. Most budget competition is within each department of State government. It is there that major tradeoffs can be proposed by department heads with reasonable, but not certain, probability that the Governor (and executive budget agency) and legislature will respect their



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choices. A minor example is the tradeoff between equipment purchase and leasing. A major example is the choice between institutional programs and community programs in mental health.

In many States, the practical, though not theoretical, impact of the department head is reduced because the unit of appropriations is considerably smaller than the department. Departmental budgets are often broken into two dimensions: (1) objects of expenditure such as wages and salaries, equipment, and contractual services and (2) organizational units and/or programs such as Medicaid or individual mental health facilities. The consideration of major programs such as Medicaid separate from other departmental appropriations is significant when major adjustments to current service spending and tax patterns are necessary.

## **Procedures With Unbalanced Budgets**

When projected revenue and spending do not balance, informal State procedures take over. These involve agreement among budget negotiators, typically legislative leaders and the Governor. The mechanics vary in ways that are significant to the players but not in the overall perspective of budgeting for health care.

The negotiators typically take as given the baseline budget with only minor changes. Their focus is on a few locally controversial decisions and on the big ticket items. These include (1) all significant proposals to raise revenue, (2) the school aid formula, (3) the general level of support for higher education and tuition policy, (4) employee compensation, (5) welfare payment levels and eligibility changes, (6) Medicaid reimbursement levels and eligibility changes, and, in some States, (7) local aid.

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## Overruns and Supplemental Appropriations

Supplemental appropriations are discouraged in public (and private) budgeting. They are traditionally reserved for situations that could not have been contemplated in advance. Examples are natural disasters, unexpected court decisions, and missed predictions such as underestimating the number of welfare recipients.

Medicaid gives rise to such events just as other programs do. In recent years, Medicaid has increasingly required supplemental appropriations in many States.

In simple terms, State officials have been enacting initial budgets which provide percentage increases for Medicaid that are roughly equal to, and often below, the increases for education or for total State spending. By overrunning baseline appropriations and seeking supplemental appropriations, they have used a little-noticed process to create Medicaid percentage increases roughly double those of education. This occurs with no significant debate over priorities. The following year's baseline budget captures the gains of the prior year and the process is repeated.

In its recent preliminary report, *State Budget and Tax Actions in 1991*, the National Conference of State Legislatures stated that post-budget actions in FY 1991 provided a major reorganization of spending priorities. As the table shows, the result was to the benefit of corrections and Medicaid and at the expense of education. NCSL comments that the same phenomenon is likely to appear when the FY 1992 results are tallied, with Medicaid and corrections again outpacing appropriated amounts.

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**Percentage Increase of Budgeted and Actual FY 1991  
Spending Increases Over FY 1990 Actual Spending**

	Regular Budget	Adjustments	Final Increase
Public Schools	7.9	-4.9	3.0
Higher Education	5.8	-6.7	-0.9
Corrections	12.5	5.1	17.6
Medicaid	15.9	6.6	22.5

The differences between the final increase and the increase in the budget are large. States, according to the NCSL survey, cut higher education and provided less than the increase required to match inflation for elementary and secondary education. This permitted increases of 18 percent for corrections and 22 percent for health care for the poor. Could a budget with this result have obtained enough votes to pass in State legislatures? The answer is unknowable, as legislatures were presented with a quite different budget, as shown in the first column.

The situation was even more dramatic in FY 1990 and FY 1989. Enacted budgets provided roughly equal increases for Medicaid and education, but after supplemental appropriations, the Medicaid increase was much larger.

## **Overruns in Individual States**

For the past 2 years, *State Policy Reports* has compared original Medicaid budgets with ultimate Medicaid spending for selected States. The results, shown in the tables below, show a consistent pattern of overruns in FY 1990 and inconsistent patterns for FY 1991.

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## FY 1990

In its first November 1990 issue, *Reports* made the calculation for the seven States shown below. It shows that fully two-thirds of the increased money spent on Medicaid in FY 1990 was not initially budgeted. These seven States increased their Medicaid spending by an average of more than 20 percent in FY 1990, but when those budgets were originally adopted, they had provided for only a 7-percent increase. The difference, almost 15 percent, came from supplemental appropriations. The effect of such an approach is that most of the Medicaid increase was hidden from the public.

## FY 1991

The setting and implementation of Medicaid budgets for FY 1991 brought out some of the less-attractive aspects of State budgeting processes. The

The Escalation of Medicaid Costs In FY 1990  
Percentage Increase From FY 1989

State	Budgeted	Not Budgeted	Total
California	10.3	4.1	14.4
New York	1.8	37.9	39.7
Texas	19.6	6.3	25.9
Pennsylvania	5.2	5.9	11.1
Ohio	9.5	6.5	16.0
Michigan	-2.4	6.8	4.3
New Jersey	8.2	2.1	10.3
7-State Average	7.0	14.8	21.8

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amounts appropriated have not corresponded to the amounts spent or, in many States, even been close. Many factors were at work, including underbudgeting, shifting of expenses from one fiscal year to another, and shifting from one fund to another. All of these difficulties appear in the statistics shown in the table below, which comes from the first November 1991 issue of *State Policy Reports*.

The table is based on legislative fiscal officers' reports to the National Conference of State Legislatures for its annual fiscal survey. *Reports* compared three figures from the largest 15 States, which have two-thirds of the Nation's population: (1) what was spent for Medicaid in FY 1990, (2) what was approved in the FY 1991 budgets for Medicaid as reported last October, and (3) what was actually spent as reported this October. The results are shown as percentage changes. For example, California budgeted for a 14.1-percent increase but finished the year with 21-percent higher spending, requiring supplemental appropriations authority of 7 percent.

The results are literally incredible, in the sense of not being believable.

**Assessing the FY 1991 Results:** The gap between estimated increases and actual increases was more like a chasm. The average deviation between predicted and actual increases was 21 percent—like estimating a 10-percent increase and getting an 11-percent cut or a 31-percent increase. By contrast, estimating errors of 2 percent or less are common in revenue estimating, and a large error, like failing to predict a recession, would be in the 4 to 8 percent range at most. The chasm has three components contributing in unknown proportions but all producing less than complete accuracy: (1) misestimates of caseload and cost, (2) deliberate misreporting, and (3) policy changes after the budgets were enacted.



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**Percentage Increases In FY 1991 Medicaid Spending**

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State	Budgeted	Actual	Supplemental
<u>Relatively Normal Patterns</u>			
California	14.1	21.0	7.0
Texas	14.7	27.9	13.2
Ohio	8.9	20.7	11.8
Michigan	-2.3	13.5	15.9
New Jersey	13.7	30.7	17.0
Virginia	19.1	28.6	9.5
Indiana	24.5	22.3	-2.2
SEVEN STATES, Average	13.2	23.5	10.3
<u>Spending Below Appropriations</u>			
UNITED STATES, Total	13.8	9.9	-3.8
Florida	60.3	48.7	-11.6
Georgia	34.0	27.9	-6.1
New York	11.8	-8.8	-20.6
Illinois	6.4	-42.0	-48.4
<u>Unlikely Spending Increases</u>			
Missouri	11.7	35.2	23.5
North Carolina	19.1	69.0	49.9
Pennsylvania	4.3	59.0	54.7
<u>Unwilling To Report</u>			
Massachusetts	21.9	n/a	n/a

Besides being large, the errors are in the wrong direction. State officials spent FY 1991 complaining about unanticipated costs, escalating provider charges, increasing caseloads, and unbearable mandates in Medicaid that increased their costs. Cost increases caused by these factors were cornerstones of complaints to the Federal Government about mandates, sharp cutbacks in other State spending, and tax increases. But as shown in the

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U.S. total line on the table, the percentage increase nationally was less than originally budgeted.

The aberrations in individual States are large enough to affect what is reported as national totals. Medicaid costs are increasing in the 15-25 percent range nationwide, with deviations above and below in individual States as shown in the seven States with relatively normal patterns. This range is reflected in State reports on actual spending and in the reimbursement claims States make for Federal cost sharing. It is not reflected in the national total shown on the table, because the large negative growth numbers from some States drag down the national increase to 9.9 percent.

The table tells many other stories. First, budgeting and reporting Medicaid spending exhibit many abnormal patterns. Seven States had normal patterns. Seven did not. One (Massachusetts) did not report at all.

Second, it is a normal pattern for Medicaid to be underbudgeted. In the seven "normal" States, only 56 percent of spending was budgeted while 44 percent was left for supplemental appropriations. On an unweighted average basis, legislators and taxpayers of those States signed up for a 13-percent increase in Medicaid and wound up buying a 24-percent increase.

Third, there are interesting stories in the other States. The large negative for Illinois does not represent real savings but a deliberate decision to get through the 1990 legislative session without major tax increases by lengthening the Medicaid bill payment cycle. Total spending in the year drops for the same reason it would if a homeowner skipped a couple of mortgage payments. New York's decline probably is a smaller dose of the same medicine.

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That Illinois would delay paying Medicaid bills in FY 1991 to lower spending and avoid a tax increase may not be laudable financial practice, but it is understandable. But why would Missouri, North Carolina, and Pennsylvania increase their spending? One plausible reason is to get money for a cause perceived as not being popular out of the limelight by moving it from the new FY 1992 budget to the obscure FY 1991 supplemental budget. Each State adopted a tax increase for FY 1992, though Missouri's was rejected by the voters in November of 1991. By shifting cost overruns in Medicaid to FY 1991, the tax increase could be discussed as being necessary for State programs across the board, particularly education, not Medicaid.

## Underbudgeting as a Practice

In recent years, cost overruns and the ensuing pursuit of supplemental appropriations have become acceptable. That is, Medicaid administrators routinely obligate (and usually spend) money at the pace called for by programmatic decisions even if the resulting spending will exceed appropriations. Challenges to this policy are fewer each year. In 1990, they arose only in Kansas and Texas. In both cases, key decisionmakers noted a potential shortfall and asserted, in accord with traditional theory, that adjustments had to be made. They announced benefit cuts, eligibility restrictions, and reimbursement controls. In response to a public outcry, they then dropped these policies in favor of assuming a supplemental appropriation that would salvage their budgets before they ran out of money.

It is easy to see where this logic leads. If having a low appropriation for Medicaid does no harm programmatically, why not keep Medicaid appropriations low? The advantages are many. The budgeted increase for Medicaid can be kept below that for education, a politically sensitive point.

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In some cases, tax increases can be avoided. In others, spending on other programs can be higher than it would otherwise be.

The practice of deliberate underbudgeting of Medicaid has become so common that local commentators widely note it, with Michigan one of the best examples. In other cases, the underbudgeting is less flagrant, with budgets below current service levels calculated to reflect savings associated with policy changes. But for one reason or another, the changes are not made. New York and California are both examples of this approach. The underbudgeting is so flagrant that the National Conference of State Legislatures's preliminary report on State budget actions in 1991 contains a strong caveat to the effect that the Medicaid numbers are not to be believed.

## **Raising Taxes and Convincing the Electorate**

During 1990 and in the first half of 1991, more than half the States enacted major increases in taxes such as adding a percentage to the sales tax or increasing income tax rates. More such increases are on the way in the latter part of 1991 or 1992, even if the economy recovers quickly from recession.

Not one of those tax increases was justified to the legislators who voted for it or to the electorate as providing money for Medicaid. Yet comparing the spending changes to the revenue changes suggests that much of the added purchasing power did go to Medicaid.

The State tax increases have had two rationales: (1) "keeping the doors open" and (2) supporting education, sometimes combined with something other than Medicaid or welfare.

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"Keeping the doors open" increases were common in 1991, particularly east of the Mississippi River. The argument is that added money is needed to avoid cuts in key programs, particularly education. Examples of States following this approach in 1991 include New York, North Carolina, and Vermont as well as California.

## **Education as the Rationale for State Tax Increases**

Tax measures using education as their rationale usually reflect a budget with Medicaid fully funded and education not well funded. The revenue measure is then tied to the education component.

This strategy was pursued in Mississippi in 1989, resulting in major fiscal problems for education when lawmakers could not agree on the form of financing. It is reflected in the current (FY 1992) Tennessee budget, where discussion of raising taxes is concentrated on financing schools. It was reflected in Oklahoma's budget in 1989, finally enacted with a tax increase in 1990. Education plus local governments were the listed beneficiaries of the 1989 Illinois tax increase. The Missouri tax increase, put on the November 1991 ballot by the legislature, devotes a small amount of increased revenue to economic development and splits the rest between elementary and secondary education and higher education.

So far, the logic of these increases has proven persuasive with the electorate as well as with legislators. The most recent example was public rejection of a repeal initiative in Oklahoma in October. The original 1990 enactment was backed by elected officials, educators, and business leaders. The campaign to

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retain the tax and education reform measure was based on the concept that education would lose the revenue generated by the tax.

To sell tax increases on this basis, State officials are giving the public tabulations and projections. These generally assume that all, or nearly all, growth in revenue from existing sources is associated with non-education programs such as Medicaid and that all new revenue is associated with education. Critics can do different math, as they have done in Kentucky after the major tax increases of 1989. The alternative approach takes all the increased revenue from new taxes and growth in existing taxes. It is compared to all the growth in programs. So if 50 percent of the expanded spending was corrections and Medicaid, 50 percent of the new tax money is concluded to be for those programs.

For proponents, associating tax increases with education may be preferable to associating them with Medicaid or other programs but is no guarantee of popularity. For example, public protests over the New Jersey 1990 increases have appeared in demonstrations, public opinion polls, and the 1991 legislative elections. In late 1991, Missouri voters rejected by a two-to-one margin the tax package for education submitted to them by the legislature.

## **Education Feels the Pinch**

Educators are becoming increasingly sensitive about being used as the basis for selling revenue increases but then not getting the money. As a result, there is a growth in interest in earmarking revenues.

In the late 1980s, in most States there was enough money to keep nearly all the spending groups reasonably happy. In 1991, being under budget pressure

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### Percentage Change in University Appropriations, FY 1992

Rank	State	Percent
1	Oregon	-11.0
2	Massachusetts	-10.0
3	Tennessee	-10.0
4	Connecticut	-8.0
5	New Jersey	-8.0
6	Rhode Island	-8.0
7	California	-7.9
8	Vermont	-7.0
9	Minnesota	-6.0
10	New Hampshire	-5.5
11	New York	-5.0
12	Virginia	-5.0
13	Nebraska	-4.0
14	Ohio	-4.0
15	Kansas	-3.5
16	North Carolina	-3.0
17	Alaska	-2.5
18	Mississippi	-2.5
19	Maryland	-2.0
20	Washington	-1.6
21	Wisconsin	-1.0

translated into absolute dollar cuts for some portions of education. For example, a recent survey by the American Association of State Colleges and Universities found that FY 1992 appropriations for higher education actually dropped in nearly half the States, and increases exceeded 5 percent in only eight States. The median increase, according to this survey, was only about 2 percent, well below the rate of inflation. The major cuts are shown above.

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# THE FISCAL ENVIRONMENT

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## Introduction

Given the procedures of State budgeting, the fiscal circumstances of State governments have a major impact on who bears the burdens of Medicaid costs. To summarize the conclusions of the following sections of this report:

- When the current service budget is balanced, large Medicaid increases come at the expense of (1) tax cuts and (2) growth of other programs. The Medicaid growth and inflation-matching growth are accommodated without tax increases. This was the situation in the late 1980s.
- When the current service budget is seriously out of balance, large Medicaid increases come at the expense of (1) other programs, with their growth often below inflation-matching rates and (2) taxpayers faced with tax increases.

These differences mean that the impact of future Medicaid cost increases will depend upon the fiscal outlook of State governments for the 1990s.

## The Outlook for State Finances

Working out the details of work load and revenue projections is complicated enough so that most studies of the State and local financial outlook are the length of short books. Over decades of such research, these studies conclude that State and local governments in the aggregate can finance current services

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with current taxes. In simple terms, inflation in costs is generally matched by inflation in revenues. In fact, many academically oriented studies see a potential surplus in State and local accounts.

These analyses suggest a possible "fiscal dividend," available for tax cuts and/or expanded spending on both old and new programs. Put another way, if these assessments are to be believed, in the 1990s State and local governments in the aggregate do not face major difficulties in funding their current level of activity from their current tax structures. In a current services world, there is no inherent long-term fiscal crisis.

Not everyone agrees with this finding. The latest review of the fiscal outlook using quantified projections was the congressionally mandated Treasury Department study of the mid-1980s. Organizations of State and local officials strongly objected to its conclusion that State and local current service budgets were potentially in surplus over the next decade.

These studies fly in the face of common knowledge of how tight State budgets are. They also differ from *The State Fiscal Agenda For The 1990s* published by the National Conference of State Legislatures in 1990. There are systematic reasons for differences. First, State resources will always be scarce in the sense that there are more apparently good ideas for spending than resources if ideas for new initiatives are counted in addition to current services. Second, business cycles will always lead to fiscal crises if States adjust spending and revenues to the upswing; so revenues will not cover spending in recession. Third, there is room for major differences in projecting Federal mandates and minor, but significant, differences in projections of economic growth.

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## Assessing the Fiscal Outlook

There is a standard methodology for examining a State's fiscal outlook. First assumptions/predictions are made about both the Nation's economy and about projected demographic changes. Those assumptions are processed through simple models to produce projections of spending from current policies and projections of revenue from current taxes and assumed Federal aid. The results are then compared.

A critical variable in revenue projections is the growth rate in the inflation-adjusted gross national product (real GNP). That growth was in the 2-4 percent range during the 1980s. Both Federal and long-term State projections, like those done in California, predict growth in this same range, with 3 percent a convenient number for purposes of this paper. Cyclical variations—recession and recovery—are assumed in Federal and State estimates but not predicted for any particular year.

A second major economic variable is the rate of inflation. In general, State and local finances are not particularly susceptible to inflation changes because roughly equal impacts are felt in higher revenues and higher spending. Inflation does have some impact on the distribution of tax burdens (e.g., more on personal income taxpayers and less on excise taxpayers) and spending benefits, but not enough to affect the overall outlook.

The major variable affecting spending projections is demographics. Some programs rely upon total population. Other programs are based upon special populations, particularly school-age children. In many cases, the population to be served is at least partially dependent upon public policy choices. For example, the number of students in public colleges has something to do with how much tuition is charged and how much student aid is available. The

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Aid For Families With Dependent Children (AFDC) beneficiary population is a function of the eligibility criteria, outreach programs, and generosity of the benefits. The Medicaid population is a function of AFDC eligibility, the existence of and criteria for a "medically needy" program, federally mandated eligibility, and how asset and income tests are administered. The prison population depends upon activity levels in law enforcement, sentencing guidelines, procedures for probation, and how much sentences are reduced by good time and early-release programs.

## **Balanced Budgets in the Aggregate**

Revenue projections assume that the State receipts will reflect a pro rata share of the estimated 3-percent GNP growth, but population is increasing at an average rate of 1 percent per year. So spending projections assume a 1-percent real annual increase in order to handle increased populations.

The difference between 3 percent GNP growth and 1 percent population growth more or less reflects the real growth in individual living standards resulting from higher productivity in the American economy. It appears as real wage growth in the private sector. State governments are likely to make approximately the same adjustments in their employee pay and in prices for what they purchase, particularly purchases from labor-intensive activities such as social work and health care.

Specifically this means that State governments should, without raising taxes, be able to afford inflationary increases in employee pay, Medicaid reimbursements, welfare cash payments, and purchases of materials. In addition, there should be about a 2-percent annual increment available for further increases in compensation or, if compensation gains are limited, for

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new initiatives. In this context, price increases above inflation such as those experienced in health care worsen the situation. So do work-load changes above population's 1-percent growth rate, such as the growth in prison population and Medicaid utilization. Conversely, there can be good news, such as education enrollment growth lagging total population growth in the 1990s.

## Fiscal Disparities

These aggregate statistics conceal considerable differences among individual governments. In extreme cases, the States with the largest inherent fiscal problems have lower-than-average tax bases combined with higher-than-average needs for spending. The extremes among States are illustrated in the next table. *States In Profile*, the source of these data, has identical information for the 50 States which indicate other examples of major differences, though not quite as large as those of Connecticut and Mississippi.

Disparities Among States

Indicator	Connecticut	United States	Mississippi
Per Capita Personal Income in 1990	\$25,500	\$18,700	\$12,600
Tax Capacity (ACIR) as % of National Average, 1988	143	100	65
% of Population in Poverty, late 1980s	6.3	13.4	25.8
Medicaid Recipients as % of Population	6.5	8.7	13.9
School-Age Children as % of Population, 1988	17	18	22



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These disparities have a major impact on the ability of different States to finance their activities and comply with any mandates. The disparities are even more significant for health care financed by local governments.<sup>12</sup>

## **Federal Impacts on the State and Local Fiscal Outlook**

Much of the fiscal outlook for State and local governments in the 1990s will be controlled by Federal policy decisions, past and future. Of those decisions, those affecting mandates will be much more significant than those involving actual grant outlays, just as was the case in the 1980s. A substantial case can be made that Federal decisions ate up much of the flexibility in State and local finances in the 1980s and had much to do with many tax increases. A strong case can be made that this will be the case in the 1990s as well, even considering only those mandates already in existence.

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<sup>12</sup>There are massive disparities among the roughly 80,000 local governments in the United States. Some jurisdictions combine extraordinary needs for public services with low tax bases. The most discussed such situations are Eastern central cities. Quantitatively, however, the most serious mismatches are elsewhere. One example is the school district with large numbers of children to educate, little or no commercial and industrial property to tax, and low residential property values. Examples are found in rural areas such as the Mississippi Delta and Mexican border areas of the Southwest. Another example is the close-in municipality near major cities such as Camden, Chelsea, East Cleveland, East St. Louis, Newark, and Yonkers. Whether such disparities should trigger Federal action is a continuing dispute. They are worth remembering in the present context as a reminder that the aggregate picture for local governments conceals considerable diversity.

The State diversity has a large impact on health care financing potentials. The local diversity is important only in a few situations. First, some States require substantial local participation in Medicaid finance, a situation that is particularly important for New York City finances. Second, in some areas there are substantial local health care outlays for indigent medical care (e.g., California) or local hospitals (e.g., Georgia).

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The fiscal impact of mandates is often underestimated because attention is focused on recent Congressional action, such as requiring Medicaid coverage for young children. Often more important are mandates from older legislation now taking effect and mandates that appear through the Federal courts.

Texas recently finished a special legislative session in which one of the announced objectives of the Governor and legislative leaders was reducing the large percentage—some said as large as 80 percent—of the Texas budget that was under the control of the courts. The court controls included school finance (a strictly State issue) and Federal court and Federal agency mandates governing the size and management of the corrections and mental health systems as well as mandates governing health care and various social service programs.

State and local financial circumstances through the 1990s will also be affected by Federal grant spending, however. Clearly, the creation of significant new Federal aid programs supporting major categories of State and local spending, like education, and/or a resumption of general revenue sharing could bail these governments out of their fiscal problems. Federal assumption of major portions of AFDC or Medicaid costs could have the same effect. Some State and local officials see such options as a realistic use of the "fiscal dividend" resulting from greatly reduced defense outlays. Conversely, many State and local officials, particularly local ones, fear a continuing erosion of the purchasing power of Federal assistance.



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# WHERE MONEY FOR HEALTH CARE COMES FROM

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## Introduction

Determining the source of State money to finance Medicaid is not easy. Because (rightly or wrongly) the program is not perceived as having widespread support, legislators and governors never explicitly raise money for it. No legislature in history has cut education to fund Medicaid. No legislature has raised taxes to fund Medicaid. Legislators do raise money for education by tax increases. They also call for sacrifices in other programs to balance "the budget" and seek tax increases for budget balance and keeping open the doors of State government. So the inquiry over where the Medicaid money comes from is inherently complex. How Medicaid resources have been made available, and at whose expense, depends on several circumstances.

## Circumstances of Medicaid Budgeting

The integration of the institutional and the fiscal environments discussed earlier results in a matrix of possible budgetary situations. The critical variables are (1) whether cost increases are anticipated or not—the amount and timing of information available to decisionmakers, (2) the condition of State finances—how tight the State budget is perceived to be at the time the decisions are made—and (3) the type of cost involved, i.e., discretionary or mandatory.

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Anticipated costs are those known when the key budget decisions, particularly the setting of annual appropriations, are made. Unanticipated costs are those associated with appropriation overruns that have been common with Medicaid. The State financial condition is expressed by the current service budget, which can be about balanced or show surplus or deficit.

Mandatory cost increases in health care budgets might result from price changes for existing services, changes in technology and health care utilization, Federal mandates, or changes in the eligible population occurring without changes in eligibility criteria. Discretionary spending includes (1) new or expanded public health programs such as health research and special programs for dealing with AIDS victims, (2) expansion of Medicaid eligibility, and (3) expansion of covered services in Medicaid. To some extent, the level of reimbursement for health care providers in Medicaid is also viewed as discretionary.

The full matrix of the combinations of these circumstances looks like this:

	Deficit	Balance	Surplus
Mandatory	Anticipated	Anticipated	Anticipated
	Unanticipated	Unanticipated	Unanticipated
Discretionary	Anticipated	Anticipated	Anticipated
	Unanticipated	Unanticipated	Unanticipated

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The last row is meaningless. Discretionary cost increases cannot be unanticipated. So there are nine differing conditions for assessing impacts of Medicaid cost increases.

## **Budgeting for Mandatory Health Care Cost Increases**

Most of the State spending increases for Medicaid in the late 1980s and early 1990s have been "mandatory" from a State budgeting perspective. They have been caused by such factors as (1) Federal mandates, (2) demographic changes, (3) changes in doctrines of appropriate treatments, and (4) changes in provider reimbursements viewed as necessary under the differing budgeting logics and health care laws of the individual States. While there have been objections to some of these changes and attempts to attenuate their fiscal effects, State officials have been accepting their financial implications sooner or later.

As would be expected, the mandatory increases find their way into State spending in one way or another.

## **Mandatory Increases and Budget Surplus**

The simplest case arises when mandatory cost increases are unanticipated and the State budget is in surplus. This happened in many States in the late 1980s. Medicaid spending outran appropriations, but revenues outran estimates. In the middle of the fiscal year, Governors recommended supplemental appropriations and reported the money was there to pay for



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them. The net effect was to reduce the surplus to be carried into the following year. The loser was whatever program(s) would have benefited from higher spending the following year.

When mandatory increases are anticipated in the budget process and the current service budget is in surplus, the increases have simply been included in the budget, although sometimes underestimated. The losers have been the other candidates for funding from that budget—other programs and, rarely, tax cuts.

When State budgets are in surplus condition, there is generally little or no attempt to make significant cuts in existing health care spending nor to avoid those cost increases that appear to be mandatory. The situation is analogous to a household experiencing an increase in its electric and water bills while experiencing an even larger increase in its income. As a result, Medicaid program growth was accommodated in most of the States in the late 1980s without significant opposition.<sup>13</sup>

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<sup>13</sup>Taxpayers' interests were not threatened, because tax increases were not at stake and tax cuts were not being considered. Spending-oriented groups make it a general practice not to criticize or lobby against other spending. This policy is not challengeable at times when the potentially opposing groups are all receiving funding. This was the case in the late 1980s when, for example, teacher compensation increases exceeded inflation while class sizes dropped. Ohio, Nevada, and Virginia are examples of the easy absorption of Medicaid costs in the late 1980s. Anticipated mandatory Medicaid costs went into approved budgets, although they were often underestimated. Cost overruns were handled in supplemental budgets which fortuitously coincided with announcements that more revenue than anticipated would be available.

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## Mandatory Increases and Tight Budgets

When spending increases for Medicaid are mandatory and fiscal conditions are not surplus, the procedures differ somewhat. This is a common situation State officials faced in the late 1980s and into 1990. There is a kind of hierarchy for dealing with budget-busting "mandatory" increases in any spending items in State budgets. First, there is what psychologists would call denial. This is a decision like "Medicaid cannot cost that much."

In the politics of the budget process, denial is not an irrational strategy. It can, and has, successfully taken elected officials through election time without budget cuts or tax increases. It is about the only explanation for decisions on Medicaid budgets in Michigan (and other States) in 1990 and Ohio in 1991. There are not detailed rationales for the budget results, which are widely disbelieved and often not supported even by legislative staffs, State budget offices, and the agencies administering the programs. Denial turns what should be an anticipated cost into a surprise at a later point in time. There are also examples of more sophisticated forms of denial. These take precise forms such as optimistic views of the number of persons receiving services, of the quantity of services to be consumed, of the prices to be encountered, and of the successes of efforts to control costs by various mechanisms.

Intentionally or not, denial turns a tough decision to appropriate large increases for Medicaid in the regular budget into an easy one to make deficiency appropriations.

Absent denial, the State budget processes typically look for each budgeting unit to absorb its own cost increases within a statewide budget guideline.

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Such a guideline might be no increases, increases of no more than 3 percent, no increases except for workload adjustment, or the like. This puts higher budgetary pressures on some programs than on others. First, it concentrates pressures on the program itself, so that Medicaid increases from increased numbers of recipients lead to pressures for reduced services and lower reimbursement rates.

Second, it concentrates pressures on the programs in the same budgetary unit as Medicaid. This varies substantially among the States because of differing agency organization and budget categories. In Texas, the pressure has been on all social and health service programs. In Massachusetts, the pressure tends to be on all programs equally because Medicaid is recognized as a separate cost center. Where Medicaid is organized with health and separate from social service, the pressure would be on health programs.

Third, the large increases of Medicaid or other programs simply add to budget pressures affecting all other spending. While quantification is not possible, this has been the impact of the mandatory increases of the 1980s.

## **Fighting the Mandates**

State officials have not been totally complacent about the factors driving Medicaid costs. They have been exerting considerable effort to get the Federal Government to avoid mandates, working on various ways to control health care costs, and looking for mechanisms to bring potential workers off welfare (and thus Medicaid) and into the work force. They continue to explore mechanisms for increasing private health insurance coverage and thus reducing Medicaid's role as an insurer of last resort.

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There is no way to quantify the effect, but Medicaid costs probably have much to do with AFDC cash payment levels. Cash payments and Medicaid are often in the same State agency and thus compete in some sense in the budget process. In a broader sense, they are both part of a package of income-tested benefits for the poor that may be viewed as competitive with benefits available to everyone. In addition, Medicaid eligibility is automatic with cash benefit eligibility. As a result, decisions to make cash eligibility easier also increase Medicaid costs, making the decisions more expensive than they would otherwise be. Higher cash assistance payments are, at least among State budget officials, believed to cause greater welfare participation and, thus, Medicaid costs.

## **Discretionary Spending for Health Care**

There has been, and will likely continue to be, an immense difference between State budgeting for mandatory health care spending and that for discretionary health care spending. These differences exist in all three budget environments—surplus, balance, and deficit.

Discretionary health spending competes in the budget process on roughly equal terms with other discretionary spending. Some examples of the other items on the shopping list in recent years:

- educational quality programs for the public schools;
- increasing the share of school spending paid by States, thereby reducing disparities among districts in per pupil spending and reducing or restraining property taxes;

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- enhancing quality in State universities;
  - increasing State efforts in economic development, including drawing tourists and providing concessions for newly locating or expanding firms;
  - assisting local government in meeting new costs and providing new technology for solid waste disposal;
  - covering transit deficits while making capital investments and system expansions to encourage ridership and maintain past investments;
  - acquiring open-space land and preserving agricultural regions in urban areas;
  - expanding treatment for substance abuse;
  - implementing changes emphasizing community mental health;
  - special task forces and State laboratory work to combat drug dealing;
  - enhanced child abuse detection and prevention activity including expensive foster care and subsidized adoption programs;
  - day care;
  - job training and placement, particularly for welfare recipients;
  - providing for the homeless and closing gaps left by Federal withdrawal from low-income housing programs; and
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- dealing with special problems of distressed central cities and impoverished rural areas.

Also on the discretionary list are less-glamorous items such as replacing or restoring public buildings, updating State computer and communications systems, and improving employee training.

All of these and more also compete with tax reduction, although that prospect is more theoretical than real. Since 1985, the instances of State tax cuts (except those financed by tax increases) have been confined to States in extraordinarily good but usually temporary fiscal circumstances, generally combined with a constitutional or statutory provision requiring cuts in such circumstances. A one-time rebate in California and several cuts in Hawaii nearly exhaust the list. Meanwhile, most States were accepting increased revenue from conforming to the changes of the 1986 Federal tax reform legislation (which broadened the income tax base) and some States increased taxes.

When the budget is balanced, discretionary spending increases for health and other programs can only be funded by (1) forcing cutbacks in existing programs and/or (2) tax increases. This is a difficult environment in which to sell increases. Through varying procedures, advocates are asked if they would like to fund their proposed discretionary increase (e.g., expanding covered services in Medicaid) by a corresponding cut in their own program (e.g., cutting eligibility). The answer by program administrators and elected officials alike is generally, "No."

A "yes" answer implies past priorities were wrong, a difficult admission. It also involves taking away a known benefit, usually defended by a constituency, for a projected one, often without a powerful constituency. It

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is not unusual for State officials to make a virtue out of a necessity in this situation. An overall policy of funding no new initiatives is adopted and widely publicized, giving elected officials "cover" from constituents seeking particular new initiatives.

With an unbalanced budget, the outlook for new discretionary spending for anything, including health care, is inherently poor. When the solution is spending cuts with no tax increases, all new initiatives are generally ruled out on principle. Otherwise, elected officials must explain why they cut one program only to fund another. The apparent exceptions generally are not exceptions. For example, in their state-of-the-State and budget messages in early 1991, some Governors talked of a new health initiative. It was nothing more than the expansion of Medicaid coverage to pregnant women and young children required by Federal mandates. When tax increases are used, with or without spending cuts, to finance the budget, one explanation is that the increase is required to keep the doors of State government open. This rationale is inconsistent with new initiatives, and so they are avoided when such tax increases are being sought.

The exciting situation is the one in which State officials seek a tax increase large enough to keep the doors open and then some. The question becomes what the "then some" is. The list of recent tax increases that fall into that category is shown below.

One interesting aspect of this list is its brevity. While there were tax increases in 20 or so States in 1990 and 30 or so in 1991, most were rationalized by the need to finance existing programs.

Health care programs do not appear on the list; yet many States with tax increases show more rapid increases in spending for Medicaid and

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**Stated Purposes of Recent Tax Increases With Purposes Other  
Than Paying for Current State Government Programs**

State	Year	Purpose
Arkansas	1991	Public Schools
Illinois	1989	Public Schools; Local Government Aid
Kentucky	1990	Public Schools
Missouri	1991	Public Schools; Higher Education
Nebraska	1989	Public Schools; Property Tax Relief
New Jersey	1990	Public Schools; Property Tax Relief
Oklahoma	1990	Public Schools
Texas	1990	Public Schools

corrections than for public schools. One inference, sometimes made by education groups and the press, was that the increase was actually for those purposes but was falsely sold as being for schools.



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## CONCLUSIONS—WHO PAYS FOR HEALTH CARE COST INCREASES?

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### There Is No Free Lunch

Medicaid cost increases are conceptually within the fiscal capacity of practically all States practically all of the time. Therefore, a debater's point can be made that they do not necessarily result in program cuts or tax increases.<sup>14</sup>

But the States do not bank money, except rarely in rainy-day funds where they expect to, and do, spend it. They do not borrow money for operating costs either, also with limited exceptions. So Medicaid increases must come from somewhere. The possibilities—not mutually exclusive—are (1) the Federal Government, (2) higher taxes, and (3) spending in other programs that is lower than it would otherwise be.

### Federal Aid

During the past 5 years, Federal aid for health care costs has been provided pursuant to policies that have remained relatively constant. This means that the Federal share of Medicaid costs (50 to 80 percent), employee health care (0 percent except for employees paid by Federal funds), and other health

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<sup>14</sup>In the aggregate, the State-funded portion of Medicaid comprises 10 to 25 percent of most State budgets. Annual Medicaid spending increases have been averaging 10 to 25 percent. It therefore follows that Medicaid is responsible for increases of only about 2 to 4 percent at a time when State budgets have been increasing by 7 percent and more. Thus, States could absorb large Medicaid cost increases and still have about 3 to 5 percent left over to cover inflation and other increases in spending.

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costs (0 to 100 percent) has remained constant while total costs have increased.

In Medicaid, this can be viewed either as the Federal Government providing substantial funding increases to meet a State burden or as States providing substantial funding increases to meet a Federal burden. In terms of resource allocation, it is best understood as each level of government providing a share.

The possible exception is bootstrap financing (see appendix B), which already represents a significant increase in Federal sharing of Medicaid program costs. If it remains legal after January 1991, it will unquestionably be adopted by more States and used for more provider categories. It is most simply thought of as an increase in the Federal share of Medicaid costs. For the portion paid by the States, it can be viewed as spreading costs of health care over all providers (and thus health consumers) rather than all taxpayers.

With the bootstrap financing exception (and arguably a few more minor ones), States have not been able to shift major health care burdens onto the Federal Government. In the other direction, there have been some Federal shifts to States such as federally mandated Medicaid payments of Medicare premiums for selected populations.

## **Increased State and Local Taxes**

State officials often increase taxes in order to "keep the doors open" and for programs perceived to be popular such as education, but never for Medicaid. This means that a State may be financing a 15-percent Medicaid increase

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from existing revenues but then require raising taxes to finance a 10-percent increase in education.

There is no objective way to deal with the question of which program caused the tax increase. Higher taxes were caused by Medicaid because without the Medicaid increase, the education increase could have been funded with no tax increase. Higher taxes were caused by education because if education had been budgeted for a smaller increase, no tax increase would have been necessary. Both statements are true.

One approach is to begin from definitions of current services and required spending found in many State budget procedures. This usually justifies a conclusion that Medicaid has not caused tax increases, as the Medicaid spending is built into the current service base and the education spending is often not. The conclusion that Medicaid cost increases have not caused tax increases is justifiable from examining the rationale given for the tax increases when they are associated with specific programs by their proponents.

Another view is to attribute to each program a share of any tax increase that is proportionate to that program's share of spending. The data problems of examining this for all 50 States are overwhelming, but it is not difficult to illustrate the methodology and show orders of magnitude.

According to the National Association of State Budget Officers' most recent expenditure survey, Medicaid accounted for 10.5 percent of State general fund spending and about 15 percent of all funds spending in FY 1991. Applying this percentage to tax increases enacted for FY 1991 financing—about \$10 billion—would suggest tax increases of about a billion associated with Medicaid.

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A much different allocation of cost responsibility occurs when the incremental change in spending is examined. This is shown by the table below.

**Total State Expenditure Changes, FY 1989-91, General Fund**

Category	Expenditures (\$ in billions)			Percent Change	Percent of Change
	FY 1991	FY 1989	Change		
Total	283.3	242.8	40.5	16.7	100
Medicaid	29.8	21.8	8.0	36.6	20
Non-Medicaid	253.5	221.0	32.5	14.7	80

Using an incremental approach to causes of tax increases would suggest some 20 percent of the relatively few tax increases in the FY 1989-91 period would be attributable to Medicaid. The same incremental approach would show a much larger Medicaid responsibility for the tax increases of 1991 for FY 1992. The total spending increases were much smaller, while the Medicaid increases were at least as large.

For example, the Governor's budget in Connecticut held aggregate spending increases to \$279 million, of which the income maintenance function (primarily Medicaid) accounted for nearly half at \$136 million. In California, the new Commission on State Finance estimates show a Medi-Cal increase for FY 1992 of \$1.6 billion. This increase is larger than the total increase for the entire California budget. Both California and Connecticut adopted major tax increases in 1991.

Another way of looking at the tax impact is to start with current service estimates except for Medicaid. This would attribute all the Medicaid effects

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at the margin and make Medicaid a contributor to tax increases in any State that raised taxes.

If Medicaid increases are assumed to be financed by tax increases, some back-of-the-envelope math (complete data are not yet available) shows the upper bounds of the impact. During FY 1992, aggregate revenue increases should be about 6 to 8 percent. Revenue growth from existing sources was about 2 to 4 percent. So, at worst, about two-thirds of all budget increases were financed by tax increases. The State share of Medicaid probably will account for a maximum of 40 percent of all budget increases. Using this methodology, it follows that (1) 40 percent of all State tax increases were caused by Medicaid, (2) Medicaid caused State taxes to increase by 1.6 percent, which is 40 percent of the 4-percent increase, and (3) two-thirds of Medicaid cost increases were financed by higher taxes and the remaining one-third by revenue growth.

Another variant is to consider the tax increases of a particular year, say 1991, as part of efforts to close a budget gap. This was the logic, for example, used in California. The gap consisted of the shortfall in FY 1991 as well as the projected shortfall in FY 1992. These State gaps were caused by spending beyond appropriations in FY 1991, spending increases projected for FY 1992, and revenue shortfalls. Given the relative contributions to the budget gaps, Medicaid would account for less than a third of the tax increases. Revenue shortfalls would be the major cause.

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Two separate observers (Gold and Hovey)<sup>15</sup> have guessed that, ignoring one time items like delayed spending and selling assets, the FY 1992 budget gaps of the States were closed half by increased taxes and half by spending cuts. This logic would suggest that 50 percent of the Medicaid cost overruns were filled by tax increases.

## **What Programs Were Sacrificed for Health Care Programs**

When cutbacks from current service levels are involved, many States begin with a presumption that all programs should sacrifice equally. The classic formulation is a uniform percentage cut that exempts only contractually obligated debt service payments. Two recent examples are Florida, where the cut was administrative (although a recent Florida court decision suggests legislative approval will be necessary), and Georgia, where it was done by the legislature on recommendation of the Governor.

Such cuts tend to come unstuck, but as much of the principle is maintained as possible. AFDC often is not ultimately cut, or cut only with a lag, because of Federal notice requirements and other reasons. Medicaid is not cut by these across-the-board means for the same reasons it is not effectively cut in the regular budgeting process. And special problems arise because of growing work load, particularly in corrections.

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<sup>15</sup>Steven Gold is with the Center for the Study of the States at the State University of New York at Albany. He is the former Director of Fiscal Studies for the National Conference of State Legislatures. He and Hovey have both been using this estimate in speeches and in press interviews. Hovey has also presented the estimates in *State Budget & Tax News* (Vol. 10, Issue 19).

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Another budget-cutting logic is uniformly applied but does not affect all programs equally. One approach is personnel oriented—hiring freezes, promotion freezes, layoffs based on percentages of the work force, and the like. Another is oriented toward particular objects of expenditures such as equipment-purchasing freezes, restraints on contractual services, and limits on travel or publications.

Social and health programs are affected by these mechanisms in much the same way as other programs. Social programs in the late 1980s and early 1990s have been particularly affected by another logic, which is not to fund any new initiatives. Certain key social programs—particularly housing, health care demonstrations programs, and programs for the homeless—fall into this category.

Two other categories of programs are often treated separately from the others. The first is higher education, where tuition serves as something of a balance wheel in State budgeting. It is common for higher education to take disproportionate losses in State funding in times of fiscal stringency, with extraordinary tuition increases making up some, but not all, of the impact. The second is local aid, particularly outside of school aid programs. State policies on local aid changes in response to fiscal problems exhibit considerable variety. In some cases, the local aid is sacrosanct, even protected by constitutional provisions. In others, it can become the method of balancing the budget, with Massachusetts a good example. In State budget terms, cuts in these two categories are considered reductions in spending. In overall economic and social terms, much of the result is higher cost somewhere else: in local property and other taxes and in higher tuition.

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## Summing Up

There have been many attempts to determine who gains when government revenues increase and who loses when revenues decline or some programs expand more rapidly than others. For reasons analyzed in appendix A, such assessments inherently cannot produce irrefutable conclusions. However, this analysis suggests some conclusions which should provide a reasonable basis for such assessments of Medicaid spending impacts as readers need to make.

*Growing Medicaid and other health costs have been shared by the Federal Government on a consistent basis.* While there have been some cost shifts, as discussed above, the division of cost responsibility has remained relatively constant. Arguments are made at the Federal and State levels that the other level should pay more.

*States have not covered these in any easily generalizable way.* It is inappropriate to attribute a disproportionate share of tax increases to Medicaid. It is equally inappropriate to attribute a disproportionate share of growth in revenues from existing taxes to Medicaid.

*Medicaid shares in the responsibility for State tax increases in proportion to its share of State spending increases.* How much responsibility this is will depend on both the year involved and the State involved. In the late 1980s, some 15 to 25 percent of tax increase money is involved. For the 1991 tax increases, the proportion may be more like 50 percent.

*Most of the growth in Medicaid has been financed by growth in revenues from existing sources.* Medicaid's growth prevented some tax cuts that might otherwise have taken place, but not many States nor much money was likely



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involved. The major impact was to cause growth in spending for non-Medicaid programs to be less than would otherwise have been the case.

*The particular programs adversely affected cannot be identified with certainty. It would appear that the effect on other programs was roughly proportional to their shares of State budgets. This would mean that the largest effect was on elementary and secondary education.*

*There is limited anecdotal evidence and logic associated with State budget processes to suggest Medicaid increases may have come disproportionately at the expense of social programs. If true, the effect was probably most pronounced in decisions to avoid increases in AFDC benefits.*





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# CONSIDERING THE BROADER ISSUES

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## Introduction

This section highlights some broader issues and trends associated with the health care cost experience in the States. It consists of observations that readers may find relevant in assessing the implications of the primary analysis.

## Federal Mandates

In addition to the usual costs and benefits associated with Federal mandates, it is important to remember where funding for them comes from within the institutional context of State and local government. Sometimes this is clear. For example, the mandates relative to identifying, publicizing, and cleaning up asbestos in schools were primarily funded out of school operating budgets at the expense of regular education programs. Medicaid coverage mandates are funded from many sources, but winners and losers are less obvious. In the extreme case which may now be occurring, Federal policy dictates much of the AFDC and Medicaid eligibility criteria (e.g., two-parent families for AFDC and children above the poverty line for Medicaid), while litigation based on Federal law determines reimbursement rates for providers. Attempting to control these criteria forces States to economize in such ways as reducing the eligible population by lower income levels for eligibility and lower cash assistance payment levels. This is not an argument that mandates are, per se, bad or good but that unintended consequences are important.

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## **Earmarked Funding**

As they find themselves squeezed in the State budget competition, advocates of other programs have looked for ways to guarantee their funding. One approach, not now widely used, is to allocate productive revenue sources for education with a constitutional protection against use for other purposes. This is done in Alabama by earmarking the income tax for schools. Another alternative is to create a constitutional requirement that a minimum percentage of the budget go to education or that education increases be at least enough to cover enrollment changes and inflation. This is what California's Proposition 98 does. A way that has proven less effective, but not ineffective, is to enact multiple-year spending plans in substantive education legislation. Many States, such as Colorado and Georgia, have done this.

The effect is to prevent other, less popular, programs from piggybacking on education's perceived popularity. The impact in extreme form can be seen from California's budget decisions in 1991. To honor Proposition 98, California raised taxes substantially while cutting back social programs, including reducing welfare grant levels.

## **States of Differing Fiscal Capacity and Need**

The disparities among States remain substantial enough so that it is not realistic to expect some to match national averages in social spending. To match national averages in spending per student, per welfare recipient, etc., Mississippi would need State and local taxes 50 percent above the national average rates and even more above the rates of its neighboring States.

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Mississippi decisionmakers believe that such tax levels would ultimately cost more in lost jobs than they would temporarily gain in revenue.

This situation argues for several policies: (1) 100 percent or near 100 percent Federal funding of minimum benefit levels as is done for food stamps and Supplemental Security Income, (2) continued reliance on mechanisms like the variable cost sharing percentage for AFDC and Medicaid that recognize differing fiscal capacity, and (3) avoidance of Federal mandates of costs that are 100 percent State and local.

## **Middle Class Benefits and Costs**

There is growing concern that State governments may find revenue raising to be increasingly difficult because what they do with the money is more oriented to programs having little relationship to the needs of most voters. In public opinion surveys, States are consistently viewed as less effective in using money than either the Federal Government or local governments. However, State income and sales taxes are consistently preferred to local property taxes and the Federal income tax. In this context, it is not surprising that States are paying an increasing share of some local costs, particularly for public schools. School spending is linked with economic development in varying ways in an attempt to create packages that appeal to everyone interested in schools or jobs. While not expensive enough to be associated with major general fund tax increases, State governments are also associated with other programs, such as State park systems, low-tuition public universities, and roads, that are perceived as having widespread benefits to all segments of society.

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The concern is that State officials will find themselves losing middle class support as they move to programs more closely oriented to the poor, with no middle class benefits. Medicaid clearly falls into this category, as do cash welfare assistance and some social services. While these have been expanding, the relative importance of parks has been declining and university tuition has been moving upward to reduce relative reliance on taxes.

The differing institutional arrangements of the States, such as whether voter initiatives are available, affect the context of any voter reactions. But the intensity of voter reaction to tax increases in Connecticut and New Jersey suggests a potential problem. Popular votes on tax measures in Oklahoma (October 1991) and Missouri (November 1991) were one indicator of sentiment. Business, labor, and political leaders of both parties supported these measures. Proponents of higher taxes outspent opponents by wide margins.

The Oklahoma measure passed by a narrow margin, while the Missouri one lost two-to-one. The difference may be due in part to the historical tendency of voters to reject new taxes that have not yet been put into effect but accept, by narrow margins, recent tax hikes already in effect. In any case, neither vote is encouraging legislators in other States to enact tax increases. Neither is the result in New Jersey in November of 1991, when voters turned out the legislative majority that enacted the tax increases of 1990.

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## APPENDIX A: WHO PAYS? NOTES ON METHODOLOGIES

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The State financing of unanticipated Medicaid costs is in many ways analogous to a middle class household that finds itself facing unanticipated costs that will continue for a time, such as costs of maintaining an elderly relative or a student in college.

One response, of course, is raising more revenue—working overtime, a second job, getting a relative to help out. Another response is borrowing part or all of the cost. These complicate what is already a difficult measurement problem, so assume them away for now.

With no borrowing and no new revenue, the household will find room for the new cost in its budget. It will make some combination of lifestyle changes, such as taking fewer vacations, buying a cheaper car, not buying stereo equipment it might otherwise have bought, eating out less, etc. The problem in this simple analogy is to find out what the household gave up.

One possible fallacy is clear even in the household case. Prior-year spending patterns are not valid indicators of spending that would have taken place in the year affected. For example, the base-year household budget may have one-time items, such as roof repair, not present in the subsequent year. The subsequent year will reflect uncontrollable changes such as higher taxes or a reduced car insurance premium because a child is away at college. So all methods must involve some mechanism for comparing (1) the actual spending in the year under study and (2) what the spending would have been absent the special cost, whether college costs for the household or Medicaid cost increases for the State.

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There are two possible methods for assessing what was foregone in the household and State budgets: (1) an interview method and (2) a budget projection method.

The interview method seeks to have the subject specify what he or she would have done with resources absent the extra expenditure being studied. As the household example suggests, particular respondents may be uncertain, not knowing, for example, whether they would have opted for discretionary spending on travel or on appliances because they never directed their attention to the hypothetical question of what they would buy with more money. Even in the household, the decision may be a joint product of several people. In the case of States, decisions are joint products of Governors, executive branch agencies, interest groups, press and media, and legislators organized in different power positions in two houses with a multitude of committees.

The budget projection method predicts the budget in the test year in some fashion. Simple rates of change can be used from past experience. Underlying work load (e.g., prisoners, schoolchildren) can be used. Inflation can be assumed as a general factor or with specific rates for items such as health care and utility charges. The result is a baseline budget that can be compared with the actual one.

Because of one-time factors affecting household and government budgets, the budget projection method is best combined with interviews. The result may be reasonably reliable for a single household but becomes prohibitively costly for a universe of 50 States, each with many decisionmakers and complicated budgets. By using aggregate data, much of it several years old, it is possible to see "winners and losers" in State budget battles, but guessing who would

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have won what if something, like Medicaid costs, were different does involve speculation.

These methods have obvious problems, but not as great as those looking forward to some future year. In those interviews, subjects are being asked to speculate on what they will do in the future under two states of facts, such as with and without Medicaid cost escalation. External variables such as the future state of public opinion, future work load factors affecting the budget, future price changes, and the like are not known to the decisionmaker.



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## **APPENDIX B: A NOTE ON BOOTSTRAP FINANCING**

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In the late 1980s, a few States began raising their Medicaid match from Medicaid providers, a practice now known as bootstrap financing. Methods included "donations," which were, in effect, used to generate new Federal money that was then returned to the provider. In other cases, there were provider "taxes," or levies on providers. Some of these were fundamentally levies on the Medicaid payment under another name. Others, not significantly at issue, were levies on all providers regardless of Medicaid participation. Federal officials objected that the donations and some provider tax programs evaded the State cost-sharing requirement.

Concerned State and provider officials convinced the Congress to pass legislation containing a prohibition against Federal action to disallow match from these sources. This action, fiscal tightness in the States, and the apparent success of existing programs encouraged States to expand rapidly their use of these programs, which is the cornerstone of budget balancing efforts in the FY 1992 budgets of many States.

The prohibition expires at the end of 1991. Administration officials have published regulations severely curtailing the practice. State officials are attempting to have the congressional prohibition extended.

The amount of money involved in State FY 1992 budgets is massive, although estimates differ depending on several factors, particularly on the precise definition of what matching sources might be disallowed. The amounts are clearly substantial enough to eliminate budget balance (or, more

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likely, exacerbate budget imbalance) in many States and create significant fiscal problems in FY 1993.

With disallowance, there would be some effort in the States to reduce Medicaid spending, particularly when State action sought to tie the spending to the availability of the matching funds. For example, in Indiana and other States, the result would be an attempt to lower provider reimbursement rates, particularly for hospitals. Such action would add to the already substantial litigation associated with provider reimbursement rates under the Boren Amendment. To deal with the remaining shortfall, States could choose between cutting back total Medicaid outlays and finding new sources of funds for the State match.

It is impossible to predict what each State will do. If money were available—say from tax revenues from an unexpected surge in the national economy—the match might be appropriated from general revenues. General tax increases would be unlikely, as many of the States involved have recently raised taxes and are re-electing legislators in November of 1992. Another possibility, which will be attractive in some States, is converting a disallowed donation or tax program into a legal tax. For example, taxes on or donations from disproportionate share hospitals could be converted to a tax on the gross receipts of all hospitals, assuming that approach to raising matching funds continued to be allowed.

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# **Corrections Spending: A Public Policy Conundrum**

Gwen A. Holden  
National Criminal Justice Association

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## A STATE BUDGETARY BURDEN

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While public pressure mounts to overhaul the Nation's education system and spiraling health care costs triggered by federally mandated Medicaid spending are draining States' coffers, corrections spending also is up significantly. The net effect of States' corrections systems construction expansion and associated operating costs likely is to continue to be felt for the foreseeable future.

Corrections spending is the second fastest growing area of State expenditures, surpassed only recently by States' Medicaid costs.

The October 1991 *Fiscal Survey of the States*, a twice-yearly fiscal analysis of States' revenues and expenditures published jointly by the National Governors' Association (NGA) and the National Association of State Budget Officers, reported<sup>16</sup> that "States' budgets are as weak as they ever have been." The prognosis is not good, the report continues; States' revenue development is at an all-time low, and "it will be extremely difficult for States to cut spending much further, since programs like Medicaid and corrections have been experiencing double-digit growth in recent years and many other State programs already have been cut."<sup>17</sup>

"Medicaid and corrections have grown unlike any programs in State budgets," the report states.<sup>18</sup>

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<sup>16</sup>National Governors' Association, National Association of State Budget Officers, *Fiscal Survey of the States*, October 1991, p. ix.

<sup>17</sup>*Ibid.* at 5.

<sup>18</sup>*Ibid.* at 3.

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. . . prison construction, which frequently is mandated by the courts, has led to increased growth in corrections spending. Total (Federal and State) corrections spending grew 18.7 percent in fiscal 1990 and 14.1 percent in fiscal year 1991. State spending on corrections grew 12.7 percent in fiscal 1990 and 11.4 percent in fiscal 1991.

Together, Medicaid and corrections programs account for nearly 20 percent of State budgets. They will continue to frustrate State policymakers even after the recession ends, unless action is taken to check their growth.<sup>19</sup>

From 1987 to 1991, States' Medicaid spending grew by 33 percent, from 10.2 percent of States' overall budgets in 1987 to 13.6 percent of States' budgets in 1991.<sup>20</sup> In that same period, corrections spending increased by 60 percent, from 2.5 percent of States' budgets to 4 percent.<sup>21</sup>

However, corrections not only is a major contributor to States' collective budget woes, it increasingly is becoming a source of funding anguish for other State criminal justice system agencies and programs.<sup>22</sup> A January 1990 report of California's Blue Ribbon Commission on Inmate Population

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<sup>19</sup>*Ibid.* at 5.

<sup>20</sup>Derived from the writer's analysis of 1987-91 editions of the National Association of State Budget Officers' annual *State Expenditure Report*.

<sup>21</sup>*Ibid.*

<sup>22</sup>The makeup of States' criminal justice systems varies among the States but typically encompasses adult and youth correction; probation and parole, state police, crime laboratories, police training, and other State law enforcement-related functions; criminal courts; and public defense services.

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Management asserted that "prison and jail crowding has been the criminal justice issue of the 1980s nationally, as well as throughout California." <sup>23</sup>

States' corrections spending today reflects a profound collision of public policy and resources. This Nation's citizens' collective desire to be safe in their homes and on their streets is as fundamental and personal as their desire for economic security.

That the public is not satisfied with government's management of its crime control responsibility is reflected in State and Federal legislators' press for more aggressive policing by law enforcement agencies, control of firearms purchases, and an all-out "war" on illegal drug users and traffickers, among the most prominent criminal justice initiatives.

However, the public's frustration with its criminal justice system perhaps is most evident in its call for harsher sentences for convicted criminals and its readiness to put up the money to build the prisons to house them during one of the worst economic periods in this country's history. The California commission reported that

. . . the tougher attitude of the public, legislators, and law enforcement toward crime and the continued willingness to approve funds to build and operate new facilities may well extend these trends into the twenty-first century.

While crime and arrest rates affect prison populations, there are several other policy and legislative factors which have a more

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<sup>23</sup>California Blue Ribbon Commission on Inmate Population Management, *Final Report*, January 1990, p. 2.

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direct impact on the number of individuals who are incarcerated, including sentencing, average length of stay in the institution, and parole failures that result in a return to prison.<sup>24</sup>

The commission report concludes, "Thus, the numbers incarcerated in our prisons today would appear to be as much or more the function of policies and practices in our criminal justice system as opposed to increases in crime and arrest rates." <sup>25</sup>

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<sup>24</sup>California Blue Ribbon Commission on Inmate Population Management, *Final Report*, January 1990, p. 2.

<sup>25</sup>California Blue Ribbon Commission on Inmate Population Management, *Final Report*, January 1990, p. 2.

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## CRIME RATES AND SPENDING INCREASES

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The troubled relationship between public safety policy and the corrections system pointed out by the California commission is visible clearly when reported crime rates and prison populations are examined.

While crime statistics indicate significant decreases in both crime levels (numbers of crimes committed) and crime rates (change in numbers of crimes committed) overall, the Nation's prison populations are growing disproportionately. An October 1991 report from the U.S. Department of Justice, Bureau of Justice Statistics (BJS), says that overall crime levels and rates have been decreasing since 1981, "the peak year for [crime] victimization."<sup>26</sup> The report, based upon the BJS's annual National Crime Victimization Survey (NCVS), says that the survey "measured at least 18 percent fewer household crimes and personal thefts and 8 percent fewer violent crimes in 1990 than in 1981."<sup>27</sup>

As with crime levels, crime rates—the number of crimes per 1,000 persons for personal crimes or per 1,000 households for household crimes—also dropped between 1989 and 1990. No crime category showed a significant increase in rates in 1990 . . .<sup>28</sup>

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<sup>26</sup>"Criminal Victimization in 1990: A National Crime Victimization Report," *Bureau of Justice Statistics Bulletin*, U.S. Department of Justice, Bureau of Justice Statistics, October 1991, p. 1.

<sup>27</sup>*Ibid.*

<sup>28</sup>*Ibid.*

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By contrast, correctional populations for roughly the same period grew by a startling 134 percent.<sup>29</sup> A May 1991 BJS report says that the number of State and Federal prisoners grew by 441,122 from 1980 to 1990 to a record 771,243 prisoners.<sup>30</sup>

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<sup>29</sup>"Prisoners in 1990," *Bureau of Justice Statistics Bulletin*, U.S. Department of Justice, Bureau of Justice Statistics, May 1991, p. 1.

<sup>30</sup>*Ibid.*

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## CORRECTIONS SPENDING GROWTH

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The public appears popularly to believe that incarceration in a prison is the most severe and therefore the most appropriate response to criminality. Public policymakers and legislators are acting upon that belief. The *Corrections Yearbook*, a publication of the South Salem, New York-based Criminal Justice Institute, Inc., reports that 62 new institutions were opened in 23 States during 1990, creating more than 34,000 new prison beds.<sup>31</sup> An additional 80,000 new beds currently are under construction in the States and the District of Columbia, the Institute says.<sup>32</sup>

Growth in corrections spending over the past two decades is rooted in the 1960s prisoners' rights movement that persuaded Federal and State courts that incarcerated persons have rights and that the government should be held accountable for ensuring that these rights are not violated or held liable for any violations that occur. In *Cooper v. Pate* (1964), the U.S. Supreme Court laid the groundwork for court intervention in conditions-of-confinement cases; "Federal and, to a lesser extent, State courts began to render opinions that recognized constitutional protections for inmates with regard to a broader range of aspects of prison life."<sup>33</sup>

In that case the Court ruled that inmates in State prisons and jails could sue officials under Section 1983 of the U.S. Code, which imposes civil liability on persons who deprive others of their

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<sup>31</sup>George M. and Camille Graham Camp, *The Corrections Yearbook 1991*, Criminal Justice Institute, Inc., p. 40.

<sup>32</sup>*Ibid.*, pp. 41-42.

<sup>33</sup>*The Justice System Journal*, National Center for State Courts, Institute for Court Management, Vol. 9/3, Winter 1984, p. 306.

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constitutional rights—thus ending the Court's traditional 'hands-off' policy toward conditions in correctional facilities. As a result, more and more prisoners began to seek ways of airing grievances concerning the conditions of their confinement.<sup>34</sup>

In these cases, States' correctional policy and practices concerning prisoner housing, medical and psychiatric care, recreation, and education, among others, came under close scrutiny; where conditions were found lacking, a State could face a court-ordered program of long-term and costly correctional improvements.

The influence of court mandates on States' correctional systems continues today; on January 1, 1991, 32 States were under court order to relieve crowding in all or some part of their corrections systems.

The cost to States of adding new bedspace to comply with court-ordered corrections improvements and to keep up with the public's demand for more and longer prison sentences is high. The Institute reports that the average cost for States' planned new corrections space is \$77,738 for each maximum-security bed, \$53,173 for each medium-security bed, and \$32,894 for each minimum-security bed.<sup>35</sup>

Moreover, States' prison systems operations likewise are costly. The Rockefeller Institute of Government's Center for the Study of the States reported in its November 22, 1991, issue of *State Fiscal Briefs* that States

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<sup>34</sup>*The Justice System Journal*, National Center for State Courts, Institute for Court Management, Vol. 9/3, Winter 1984, pp. 306-307.

<sup>35</sup>*Ibid.* at 40.

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spent \$17.3 billion on corrections in 1990.<sup>36</sup> The Criminal Justice Institute reports a slightly higher figure for 1990, \$18 billion, of which \$15.4 billion was used for corrections systems operations and \$2.6 billion for capital expenditures.<sup>37</sup>

Adjustments in States' sentencing policies to address current crime priorities also is producing new service and associated fiscal requirements for States' corrections systems. The Nation's "war on drugs" has produced significant increases in the numbers of offenders serving sentences in State correctional institutions for drug offenses, and this trend likely will continue. The Center for the Study of the States, in its November 1991 *State Fiscal Briefs*, cites a National Council on Crime and Delinquency report that indicates that the number of State prison admissions for drug offenses rose from 10 percent in the mid-1980s to between 25 and 30 percent today.<sup>38</sup>

The California Blue Ribbon Commission on Inmate Population Management, in its final report, states that the number of offenders admitted to State correctional facilities increased by more than five times between 1984 and 1988; "in 1989, 7.2 percent of the inmate population was serving a prison term with drug possession as their primary offense." <sup>39</sup>

Moreover, most States are reporting significant numbers of offenders with histories of substance abuse among corrections populations—76 percent of inmates in California's corrections institutions, the Commission reports; even

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<sup>36</sup>*State Fiscal Briefs*, Rockefeller Institute of Government, Center for the Study of the States, No. 2, Nov. 22, 1991, p. 1.

<sup>37</sup>*The Corrections Yearbook 1991*, pp. 47-48.

<sup>38</sup>*State Fiscal Briefs*, p. 1.

<sup>39</sup>California Blue Ribbon Commission on Inmate Population Management, *Final Report*, p. 69.

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higher percentages are reported by other States.<sup>40</sup> These offenders are a particularly resource-intensive class of inmates, often posing health and security risks within corrections institutions and requiring costly special treatment for their drug and alcohol problems.

However, corrections administrators in most States are limited by resource constraints in what they can do for substance-abusing inmates. A September 1991 U.S. General Accounting Office (GAO) report to the House Committee on Government Operations on drug treatment in States' prisons found that "nationwide, over 500,000 of the 680,000 State inmates may have substance abuse problems, but State prisons can provide drug treatment to just over 100,000."<sup>41</sup>

Many State prisons attempt to optimize their treatment capacity by targeting their more intensive treatment to those inmates nearing release. Even so, many inmates are released without receiving any drug treatment services . . .

The challenges for States to enhance prison drug treatment services are numerous. They include (1) limited funding for providing treatment services, (2) security considerations, and (3) difficulties in assuring the availability of aftercare . . .<sup>42</sup>

More and longer prison sentences and more prison bedspace may produce more prisoners, but offenders actually may be serving less time in

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<sup>40</sup>Ibid.

<sup>41</sup>U. S. General Accounting Office, *Drug Treatment: States Face Challenges in Providing Services*, Report to the Committee on Government Operations, House of Representatives, GAO/HRD-91-116, Sept. 16, 1991, p. 1.

<sup>42</sup>Ibid. at 2.

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institutions. The Center for the Study of the States reports that "while many discuss a new 'get tough on criminals' attitude, it appears that the average prison term served by felons is actually declining." <sup>43</sup>

Between 1986 and 1988, every major felony category, with the exception of larceny, recorded a decline in the average sentence. The increased reliance on incarceration is the key, not longer sentences.<sup>44</sup>

In the end, the public may not be getting what it thinks it is paying for.

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<sup>43</sup>*State Fiscal Briefs*, p. 1.

<sup>44</sup>*ibid.*





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## CORRECTIONS AND STATES' JUSTICE SPENDING

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The "get tough" politics of crime certainly is driving corrections policy and spending and perhaps is the most visible—or at least the most widely discussed—repercussion of recent crime initiatives such as the "war on drugs." But the combined effects of corrections' absorption of vast amounts of States resources and States' poor fiscal conditions are having an impact on other criminal justice agencies' budgets.

In Colorado, nearly half the State's overall criminal justice operating budget is spent on running the State's corrections system.<sup>45</sup> The State's criminal justice operating budget grew by 20 percent from FY 1990 to FY 1991 and by 17 percent from FY 1991 to FY 1992. Most of these increases, Colorado public safety officials say, were needed to finance operations of new corrections facilities and programs.

New funding for corrections construction and operating costs in Colorado, combined with State general fund cuts to offset Medicaid shortfalls, may result in termination of State-funded police officers' training this year, Colorado officials report.

Projected criminal justice spending in Pennsylvania increased at a rate 4 percent greater from FY 1991 to FY 1992 than projected spending for the Commonwealth's entire budget for the same period.<sup>46</sup> New funding for

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<sup>45</sup>Based upon information provided at the writer's request by the Colorado Department of Public Safety's Division of Criminal Justice Services, November 1991.

<sup>46</sup>Based upon information provided at the writer's request by the Pennsylvania Commission on Crime and Delinquency, November 1991.

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Pennsylvania's corrections system accounts for 18 percent of criminal justice spending projected for FY 1992.

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## MORE PROBLEMS FOR CORRECTIONS

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Coinciding with its demand for harsher punishment for murderers, rapists, and other criminals who traditionally have been held to be society's worst offenders, the public has pressed its legislators to enhance the criminal justice system's intervention in other public safety and social order concerns, creating new classes of offenders for State and local corrections programs.

Since the early 1980s, virtually every State legislature has considered, and most have enacted, statutes that require agencies of the criminal justice system to aggressively intervene in domestic violence and child abuse; remove drunken drivers from the Nation's streets; enforce court-ordered child support payments; and conduct criminal background checks of prospective firearms purchasers, child-care workers, teachers, schoolbus drivers, and others whose behavior potentially might pose a public-safety risk.

Many of these new or expanded State and local public-safety responsibilities affecting States' corrections programs and criminal justice systems operations generally have been initiated under mandates handed down by the Federal Government. While avowing State and local governments' primacy in the public-safety arena, the Federal Government in the past decade has required States to stop detaining juvenile offenders in jails; report illegal alien criminal convictions to the Federal Immigration and Naturalization Service; provide acquired immunodeficiency syndrome (AIDS)-related testing for victims of sexual abuse; and revoke driver's licenses of persons convicted of drug offenses, all with little or no Federal assistance provided to help States achieve these objectives.

Under some enacted or proposed congressional mandates, States risk losing existing Federal aid such as highway funds or criminal justice system

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improvement dollars if they are unable to comply. Under provisions of a crime bill approved by the Senate in July 1991, a State would lose its entire Justice Department, Bureau of Justice Assistance-administered Edward Byrne Memorial State and Local Assistance formula grant if it is unable to upgrade its criminal history records system to 80 percent completeness within a 5-year period.<sup>47</sup> The House version of the crime bill, passed in October 1991, would require States to spend a portion of their Federal criminal justice assistance formula grants to formulate and implement drug-testing programs for arrestees, inmates, and other correctional populations.<sup>48</sup> A congressional conference committee that has been convened to resolve differences in the House and Senate crime bills will decide whether criminal history and drug-testing requirements will be incorporated in crime legislation that the Congress hopes to enact before the first session of the 102nd adjourns in November 1991.

Both the criminal history records improvement and drug-testing initiatives would be financed by a Federal aid program that has not seen an appropriations increase in the past 2 fiscal years and that increasingly is tapped to fund new national crime priorities and favorite programs of individual Members of the Congress.

In addition, local governments' funding cutbacks and local jail crowding have compounded many States' corrections problems. County and municipally operated jails that in the early 1980s often were pressed into service to help relieve crowding in States' prison systems no longer have the bedspace available to perform this function.

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<sup>47</sup>S. 1241, The Violent Crime Control Act of 1991, passed in the U.S. Senate on July 12, 1991.

<sup>48</sup>H.R. 3371, the Omnibus Crime Prevention Act of 1991, passed in the U.S. House of Representatives on Oct. 22, 1991.

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## SOLVING THE PROBLEM

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For nearly a quarter of a century, criminal justice professionals have espoused widely the view that this country's corrections system must comprise a variety of facilities and programs if the system is expected to be responsive to society's public safety and crime control objectives and to humanely, effectively, and economically manage its criminal justice populations.

Public policymakers' and legislators' subscription to this tenet has waxed and waned over the years according to their collective view of the public's satisfaction or dissatisfaction with the job that the criminal justice system is doing. In no part of that system is the impact of this inconstancy felt more profoundly than in the field of corrections. The reality is that most offenders one day will return to the community, and the public holds the corrections system responsible for these individuals' behavior when they do. It is no accident that this Nation's system of jails and prisons is called corrections; the public expects these programs to correct the behavior of its criminals.

In its 1967 final report, the President's Commission on Law Enforcement and the Administration of Justice called for "a revolution in the way America thinks about crime" that would feature a massive overhaul of the country's corrections system.<sup>49</sup>

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<sup>49</sup>The Challenge of Crime in a Free Society: *A Report by the President's Commission on Law Enforcement and the Administration of Justice*, U.S. Government Printing Office, February 1967, p. v.

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The Commission recommended "the development of a far broader range of alternatives for dealing with offenders." <sup>50</sup> The Commission based this recommendation upon "the belief that, while there are some who must be completely segregated from society, there are many instances in which segregation does more harm than good. Furthermore, by concentrating the resources of the police, the courts, and correctional agencies on the smaller number of offenders who really need them, it should be possible to give all offenders more effective treatment." <sup>51</sup>

. . . the ineffectiveness of the present system is not really a subject of controversy. The directions of change—toward the community, toward differential handling of offenders, toward a coherent organization of services—are supported by a combination of objective evidence and informed opinion.<sup>52</sup>

"The costs of action are substantial," the Commission noted, "but the costs of inaction are immensely greater." <sup>53</sup>

Inaction would mean, in effect, that the Nation would continue to avoid, rather than confront, one of its most critical social problems; that it would accept for the next generation a huge, if not immeasurable, burden of wasted and destructive lives. Decisive action, on the other hand, could make a difference that would really matter within our time.<sup>54</sup>

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<sup>50</sup>The Challenge of Crime in a Free Society: *A Report by the President's Commission on Law Enforcement and the Administration of Justice*, U.S. Government Printing Office, February 1967, p. vii.

<sup>51</sup>*Ibid.*

<sup>52</sup>*Ibid.*, 85.

<sup>53</sup>*Ibid.*

<sup>54</sup>*Ibid.*

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Today, the Nation's Governors and States' budget officials are echoing the Commission's call for a reassessment and restructuring of States' operations and spending.

The bottom line is that 1992 is going to continue to be a very difficult year for States—perhaps the most difficult in the last decade. There are no easy solutions to the problems States face, and it is likely that many of these problems will not go away with an economic recovery. To the extent that this is true, States can serve their long-term interests best by seeking long-term solutions to some of the spending problems they face. Only with structural changes can States begin to realign their budgets in a way that will ensure balance.<sup>55</sup>

In the interests of crime control, and in light of States' current economic conditions, decisive action aimed at striking a balance among public safety policy and operational objectives, public expectations, and resources may be the only option remaining for States.

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<sup>55</sup>*Fiscal Survey of the States*, p. 3.



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# **State Strategies for Containing Health Care Costs: A Review of Selected State Programs**

Connie Wessner  
Intergovernmental Health Policy Project



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## Introduction

This paper follows up on a cost-containment report originally published by the Intergovernmental Health Policy Project (IHPP) in March 1990. In addition to covering many of the same topics addressed by that first report, this report adds sections on public-private partnerships in long-term care insurance and the resurgence of interest in certificate of need (CON) programs. More detailed profiles of State initiatives have been included in the sections on managed care, care rationing, utilization review, and revenue expansion.

Since 1985, spending on public sector health programs has outpaced most other categories of State and local expenditures. A good portion of the increase in these expenditures is the result of spiraling Medicaid costs. According to the National Council of State Legislatures, Medicaid budgets are far and away the fastest growing portion of State budgets, and annual growth in the program consistently outstrips budget projections.<sup>56</sup> The following statistics provide some insight into the strain that health care costs have placed on State and local budgets. Between 1990 and 1991, State Medicaid outlays rose by 14.4 percent; estimates for 1992 suggest that Medicaid expenditures will increase 21.8 percent over 1991 spending. Even this projected increase may underestimate actual Medicaid spending because of the growing use of earmarked revenues, such as provider-specific assessments.<sup>57</sup> HCFA and OMB have estimated that States will spend approximately \$50 billion for Medicaid in 1992 and that Federal outlays may

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<sup>56</sup>Eckl, Corina L., Hutchinson, Anthony M., and Snell, Ronald K., *State Budget and Tax Actions 1991*, NCSL, October 1991.

<sup>57</sup>Eckl, et al., op. cit.



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total \$65 billion.<sup>58</sup> In contrast, State budgets for elementary and secondary education are expected to rise by only 8.9 percent between 1991 and 1992.

Some components of rising health care costs go beyond the scope of State governments. Nevertheless, States have initiated a number of innovative and effective strategies to address the problem. Although data on actual savings are scarce, several of these approaches appear to be saving money and, as a result, are receiving increasingly broad attention and application across the country.

In their efforts to put an end to the upward spiraling of health costs, the States have discovered that their purchasing power—when dollars spent for Medicaid, indigent care, and employee health benefits are combined—gives them formidable leverage in the marketplace. And while the States have learned and will continue to learn from the private sector, the opposite is also true. Many of the experiments under way with prepayment and managed care and even prospective reimbursement under Medicaid are likely to be helpful to private purchasers.

Research contained in this report represents the work of several IHPP staff researchers and writers. In addition, the report includes some of the original work done by Susan Laudicina, the author of the first report.

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<sup>58</sup>*Better Management for Better Medicaid Estimates*, Health Care Financing Administration and Office of Management and Budget, July 1991.

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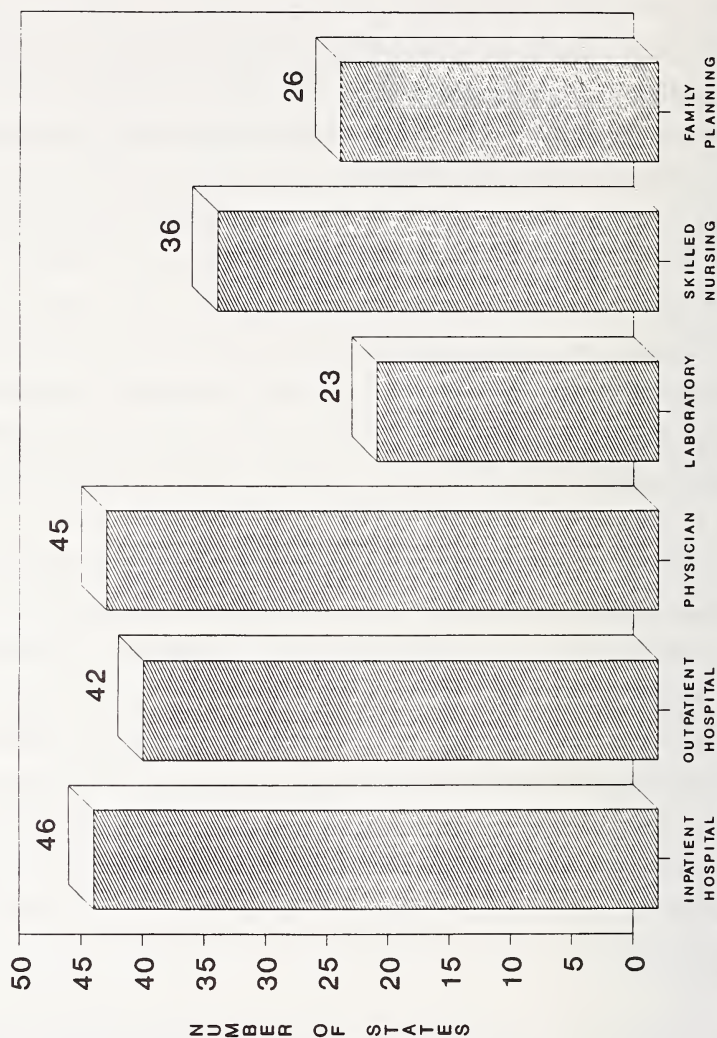
## An Exercise in Rationing?

It can be argued that "rationing" is not new to the U.S. health care system. To be sure, the Nation's market economy forms the basis on which all goods and services—including health care—are traded: Individuals who can pay receive services; individuals who cannot pay rely on the philanthropy of others or go without. Local, State, and national authorities sanction a second, more formal system of health care rationing. For example, Medicare imposes restrictions on access to care based on age, whereas the Medicaid program allows States to set "limits on the amount, duration, and scope" of coverage for its clients. Some public sector officials and researchers are now proposing models that take this traditional and, to some extent, less tangible rationing one step further: denying recipients of publicly funded health care coverage access to treatments and procedures not deemed cost effective.

Before turning to new developments in the debate over rationing, it is useful to review the nature and scope of the rationing that has long been authorized by the Medicaid program. Federal Medicaid regulations mandate that each service offered must be sufficient in amount, duration, and scope to reasonably achieve its purpose and that services provided to categorically needy individuals be equal. Within these broad requirements, however, States have some latitude to determine how often, how long, and in what form clients may utilize covered services. State-imposed restrictions, then, are established in addition to those limitations required by Federal law for a particular service.

Exhibit 1 summarizes limitations on mandatory services under Medicaid in 1988 (the most current date for which data are available). It is immediately evident from this chart that limits of one sort or another are common. Nearly all the States restrict inpatient hospital services, to some degree, by

# EXHIBIT 1 MEDICAID LIMITS ON MANDATORY SERVICES



Based on data from HCFA's *Medicare and Medicaid Data Book, 1988*.

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limiting the number of days a recipient is covered (14 States), requiring prior authorization for all or specific elective procedures (22 States), and limiting pre-operative days and/or weekend admissions (9 States). Many States also impose limits on outpatient hospital services; 11 States, for example, limit the number of visits per year or month. General limitations on physician services are also widespread; 23 States decline to cover certain services ranging from routine physicals to organ transplants. Similar types of restrictions are also placed on laboratory, skilled nursing, and family planning services.

Over the past 5 years, there has been a "new wave" of research and experimentation with a more formal type of health care rationing in this country. Proponents of the new rationing argue that the main factor driving up health costs is the explosion of and demand for new medical technology. According to this school of thought, cost increases from useful new medical technologies continue unabated, while opportunities to offset them through greater efficiency and elimination of medically unnecessary treatment are slowly exhausted. Given these competing pressures within the existing health care system, an essentially unregulated market is an inadequate and inequitable tool for successfully allocating care. Instead, patients should gain access to services through a more systematic and rational approach. Under this alternative approach, society would accept as a primary obligation providing universal access to basic care. Only after society guarantees this basic access would more expensive, specialty procedures and services be available.<sup>59</sup> Probably the best example to date of this type of comprehensive rationing is the Oregon experiment.

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<sup>59</sup>Inglehart, J., "From Research to Rationing: A Conversation with William B. Schwartz," *Health Affairs*, Vol. 8, No. 3, Fall 1989; Blank, R., *Rationing Medicine*, Columbia University Press, 1988; Callahan, D., *Setting Limits: Medical Goals in an Aging Society*, Touchstone/Simon and Schuster, 1987; and Churchill, L., *Rationing Health Care in America: Perceptions and Principles of Justice*, University of Notre Dame Press, 1987.



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Designed by Senate president and physician John Kitzhaber, Oregon's plan to restructure its Medicaid program has two important components. On the one hand, Oregon would expand coverage significantly by channeling limited resources to preventive services such as prenatal care. On the other hand, the State would limit the range of services for which Medicaid pays to a list of treatment and service priorities designated by a special 11-member Health Services Commission. The plan takes its cue from the State's 1987 decision to stop paying for organ transplants under Medicaid and was authorized by Chapter 836 (1989 Laws); it was approved by then Governor Neil Goldschmidt in July 1989.

Since 1989, Oregon has taken a number of steps to move closer to implementation of a newly designed and administered Medicaid program. Commission members began work in September 1989 to rank all available health care services, on the basis of expert testimony, cost/benefit analyses, and public hearings and meetings. (A separate subcommittee of the Commission developed similar rankings for mental health and substance abuse treatment services.) In addition to the qualitative rankings developed by the Commission, a national accounting firm was hired to complete actuarial analyses of all procedures and treatments included in the list. Using the savings derived from limiting or, in some instances, completely eliminating expensive procedures, Oregon officials plan to extend publicly supported health care services to all individuals whose incomes are below the Federal poverty level. Some reports indicate that this expansion could nearly double the number of Oregonians receiving Medicaid.

In preparing the ranked list of treatments, Commission members identified 17 categories of care, ranging from essential services to services whose value may be limited for most individuals. The Commission findings state that

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"every person is entitled to services necessary for a diagnosis." <sup>60</sup> Upon receiving a diagnosis, however, treatment options would then be matched against the following priorities:

## Essential

1. *Acute Fatal*: treatment prevents death and allows full recovery;
2. *Maternity Care*: includes most newborn disorders;
3. *Acute Fatal*: treatment prevents death but does not allow full recovery;
4. *Preventive Care for Children*: immunizations and well-child visits;
5. *Chronic Fatal*: treatment improves lifespan and quality of life;
6. *Reproductive Services*: excludes infertility services;
7. *Comfort Care*: pain management and hospice care for end-stage diseases;
8. *Preventive Dental Care*: for adults and children;

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<sup>60</sup>Overview of Commission Findings, 4/28/91.

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9. *Proven, Effective Preventive Care for Adults*: screenings, etc.

### **Very Important**

10. *Acute Nonfatal*: treatment causes return to previous health;
11. *Chronic Nonfatal*: one-time treatment improves quality of life;
12. *Acute Nonfatal*: treatment without return to previous health;
13. *Chronic Nonfatal*: repetitive treatment improves quality of life;

### **Valuable to Certain Individuals**

14. *Acute Nonfatal*: treatment speeds recovery;
15. *Infertility Services*: in vitro fertilization, artificial insemination;
16. *Less Effective Preventive Care for Adults*: routine screening for nonrisk patients;
17. *Fatal or Nonfatal*: treatment causes only minimal improvement in quality of life.

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Using this categorized list of services, the legislature can choose exactly how much to cover under a standard package of benefits and make appropriations to fund its choices. Oregon legislators, however, may not alter the priorities set by the Commission.

Having completed work on the priority list, Oregon now faces another obstacle to its efforts to revamp Medicaid. The Health Care Financing Administration (HCFA) must agree to suspend Federal rules that govern the services State Medicaid programs must provide to qualify for Federal matching funds. State officials developed a draft version of the required waiver with the help of a Washington, DC, consulting firm but delayed submission of the waiver until July 1991 after Oregon's legislature approved a \$270 million biennial Medicaid budget—enough to pay for 587 of the 709 ranked medical conditions. While the approved budget means that 122 services will be dropped from coverage, the Commission's rankings did include some services that are not covered by the existing Medicaid program. Implementation is currently set for July 1992, meaning that HCFA must respond to the State's waiver request by the end of this year if implementation is to proceed on schedule.

## **Moving to Managed Care**

For at least the last 10 years, commercial and public insurers have been experimenting with a range of managed care models with an eye toward improving access and as part of an all-out effort to control spiraling medical costs. The managed care industry has thus far gained a strong foothold in the private health care delivery system. For many public sector programs, however, it remains somewhat nebulous, loosely defined as a cost-effective method of promoting preventive care, while reducing acute and chronic care

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costs. The confusion is not so much over the desired impact of managed care but rather which of the many managed care models can best achieve the desired results.

In the search for an effective and efficient health care system, public officials are testing a variety of models: (1) health maintenance organizations (HMOs); (2) health insuring organizations (HIOs)—those that arrange services rather than serving simply as fiscal intermediaries; (3) primary case management programs; and (4) preferred provider organizations (PPOs). Some of these models rely on a capitated rate structure, while others depend on the traditional fee-for-service system. What all the models have in common, though, is that they give public sector managers the opportunity to monitor and, more importantly, shape individual health care utilization patterns.

In theory, managed care plans provide every incentive to emphasize high-quality preventive care, to diagnose and treat medical problems early—before they become more serious and costly—and to reduce costs by preventing illness or undesirable outcomes. Payers pursue these goals by insisting on prospective pricing, capitation financing, negotiated fees, and/or financial risk-sharing. In managed health care systems, providers' fortunes rise and fall with their ability to control the payer's—in this case, State and Federal Governments—costs. Frequent low-cost screening and preventive treatments mean healthier patients who use fewer hospital days, which in turn translates to lower acute and chronic care costs.

Working from these basic assumptions, public sector strategies to contain health care costs by depending on managed care can be differentiated by the populations served and the service models employed. Efforts to contain the cost of health care provided to poor and medically indigent populations have

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centered on the use of prepaid health plans and case management programs. Medicaid managed care initiatives in Massachusetts, New York, Detroit, and Philadelphia are profiled below. On the other hand, PPOs now play an important role in State employee health benefit programs and workers compensation programs. A more general discussion of PPOs' efforts follows the Medicaid managed care profiles.

## Prepaid Health Plans

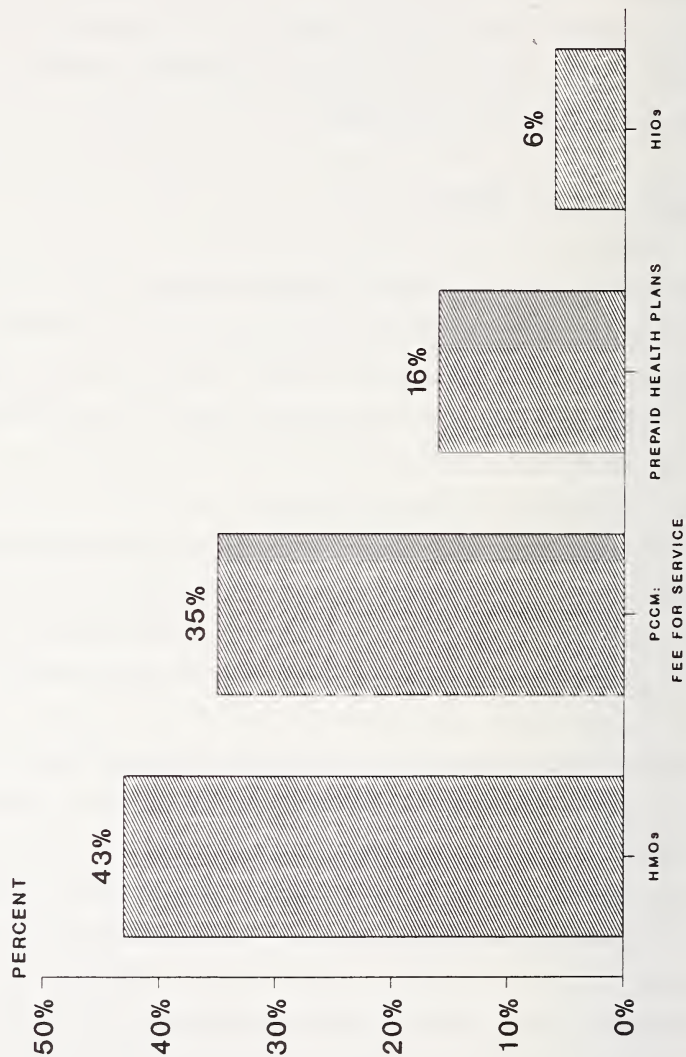
As State Medicaid budgets soar, program managers at both the State and Federal levels have become increasingly persuaded that managed care programs may be the wave of the future. Support for these programs comes not just from the estimates of potential savings but also from the perception that this savings accrues even as access to care is improved. Exhibit 2 presents the scope and nature of Medicaid enrollment in managed care programs as of May 1991. Over the last decade, the number of States introducing some form of managed care to their Medicaid programs has grown steadily. The May 1991 enrollment of just under 2.4 million represents 9.6 percent of all Medicaid recipients nationwide.<sup>61</sup>

The most widespread type of prepaid Medicaid managed care arrangement is the comprehensive HMO, which accounts for 66 percent, or just over 1 million of the total prepaid enrollees. In addition to being risk-based and offering what HCFA defines as comprehensive services, contracted HMOs must meet the following requirements: (1) limit the proportion of Medicaid/Medicare enrollees in each contracted HMO to 75 percent of total beneficiaries and (2) allow enrollees to disenroll without cause on 1 month's

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<sup>61</sup>*Report on Medicaid Managed Care Enrollment*, Health Care Financing Administration, Medicaid Bureau, Medicaid Managed Care Office, May 1991.

# EXHIBIT 2 ENROLLMENT IN MEDICAID MANAGED CARE PLANS



SOURCE: HCFA Report on Medicaid Managed Care Enrollment, May 10, 1991



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notice. Within the Federal guidelines, however, there is room for significant variation across State programs. The following profiles provide a sampling of the wide range of managed care experiments being undertaken by State Medicaid agencies.

**Detroit: The Wellness Plan.** In 1989, 2 percent of the babies born in Detroit, MI, died before reaching their first birthdays. The city's infant mortality rate (21.3/1,000), like that of many urban areas in the United States, rivaled the rates of some Third World nations. Still, in one part of Detroit, new mothers and their infants at a pre-paid health plan called Comprehensive Health Services (CHS) were beating these dismal odds. For CHS-enrolled children, the chance of living past their first birthdays was roughly double that of their counterparts elsewhere in the city. In fact, CHS' 1989 infant mortality rate (12.6/1,000) was similar to the statewide rate of 11.1/1,000 and not far from the national rate of 9.1/1,000. (Exhibit 3)

CHS patient gains in maternal and child health become all the more impressive in light of the significant numbers of Medicaid-eligible families participating in the HMO. Of the 77,000 patients served by CHS, over 60,000 (78 percent) receive Medicaid. One of the most pressing problems many providers face with Medicaid patients is their tendency not to keep appointments or follow through with treatment protocols. Such is the case at CHS. Recognizing these tendencies, however, as a major factor in the plan's ability to maintain patient health as well as minimize costs, CHS staff developed a number of coping strategies to minimize the effects of missed appointments and inconsistent followup by patients.

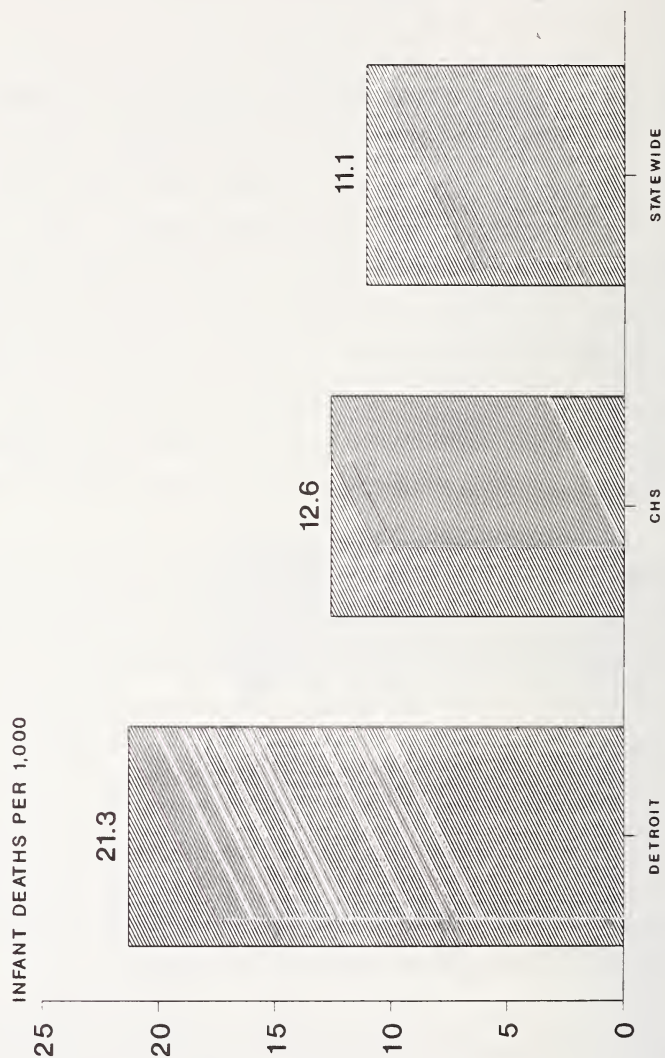
Among the coping mechanisms employed by CHS is a redesigned medical chart that has preventive checklists on the front cover. These checklists allow all CHS physicians, including specialists, to immediately assess their

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EXHIBIT 3

# SELECTED INFANT MORTALITY RATES IN MICHIGAN 1989



SOURCE: HCFA Briefing to the Secretary of DHHS, July 1991

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patients' preventive schedule and remind them to schedule upcoming screens and immunizations. CHS also designed an effective method for addressing one of the most formidable barriers to care for Medicaid recipients: on again, off again eligibility. Many providers react to this uncertainty by simply refusing or delaying treatment for patients receiving Medicaid. In contrast, CHS staff use software written by WellCorp to check patients' current Medicaid eligibility status. The program pulls in information directly from the Medicaid agency's data base and adds to that case histories and appointment schedules. CHS staff indicate that the data base, coupled with negotiated, capitated rates, removes a good deal of the uncertainty that their counterparts who receive Medicaid fee-for-service payments consistently face.

For high-risk pregnancies, CHS has teamed with the Michigan Department of Social Services (DSS) to provide enhanced managed care services. The program, known as the Maternal Services Support Program (MSSP), offers (1) prenatal health education, (2) home care visits, (3) nutritional assessments, (4) psycho-social evaluations, and (5) transportation to and from appointments. Although MSSP is available through all participating Medicaid providers, it may be more likely that eligible women receive the service if they are enrolled in CHS. With other providers, a pregnant woman must be familiar enough with MSSP to ask her physician to enroll her. CHS, in contrast, immediately registers all enrolled pregnant women for MSSP and provides a complete package of comprehensive services.

That CHS has had a positive impact on the health status of Medicaid clients in Detroit has been acknowledged by State and Federal officials alike. A recent briefing on CHS by HCFA staff estimated that Medicaid savings owing to client participation in the HMO totaled more than \$6.9 million in 1990. The same briefing outlined the dramatic reduction in infant mortality

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rates seen by CHS patients between 1988 and 1989, when the rate per thousand births dropped from 17.0 to 12.6. And, in another commonly used indicator of overall patient health, the briefing reported that CHS hospital days per thousand dropped from 768 in 1980 to 448 in 1988.<sup>62</sup>

As word of CHS' achievements has spread, health plans in other cities have begun looking to CHS as a model. Plans serving predominately low-income areas in New York and California had informal discussions with WellCorp, CHS' parent company. A similar plan in the District of Columbia has adopted many of the marketing and management strategies originally developed by CHS. Based on the enrollment rates at CHS, these marketing strategies are striking the right chord with Medicaid recipients. CHS staff think the combination of guaranteed access with a comprehensive package of services that goes beyond office visits and an occasional hospital stay is in large part the attraction for low-income patients. Among the range of services offered by CHS are courses in smoking cessation, stress management, and childbirth as well as drug rehabilitation services and nutritional counseling. Even in areas where access to fee-for-service care is adequate, providers cannot offer the same range of benefits. For example, Michigan's fee-for-service Medicaid does not reimburse eyeglass providers; under the CHS prepaid plan, however, eyeglasses are a covered service.

**Massachusetts: An Established Network of HMOs.** On January 1, 1992, Massachusetts will take the next in a series of steps to bring managed care to the majority of its Medicaid clients. On that date, the State begins converting approximately 400,000 Medicaid recipients (excluding institutionalized clients) to managed care. The decision to undertake this full-scale conversion is in part a response to the State's precarious fiscal

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<sup>62</sup>HCFA Briefing to the Secretary of the Department of Health and Human Services, July 1991.

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condition and the rising costs of Massachusetts' very generous traditional fee-for-service Medicaid program. The current move to mandated, managed care also traces its roots to initiatives begun in 1986. In that year, the State legislature established the "Health Choices" program to provide low-income families and individuals access to the same health care options available through private insurance.

At its inception, the Health Choices program was slated to offer health care services through a variety of managed care models, including HMOs, a PPO, and prepaid community health centers. As the program evolved, however, Health Choices came to focus primarily on HMO membership. By the end of FY 1988, the State had signed contracts with all the HMOs serving Massachusetts residents. As of October 1991, HMOs in Massachusetts were serving 65,000 of the State's Medicaid clients, up from 5,000 when the program began just 5 years before.

In what may be informally deemed phase two of Massachusetts' drive to mandated managed care, Medicaid recipients who elect not to enroll in one of the HMOs will be required to choose a primary care provider. Known as the Primary Care Clinician Program (PCCP), this new component of the State's managed care system will link patients with providers who agree to act as "gatekeepers" for other specialty services. In return for coordinating recipients' care, these providers will receive enhanced office visit rates. Under the current plan for PCCP, all community health centers, nurse practitioners, physicians, and outpatient departments are eligible to enroll as primary clinicians. Mental health and substance abuse services will be coordinated by regional centers. To assist clients who need help adapting to the new managed care program, client outreach and education will be a primary focus of the Department's plan for conversion to managed care.



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**New York: Developing a Statewide Managed Care System.** Like Massachusetts, New York is launching an initiative to move most of its Medicaid clients to some sort of managed care arrangement. Because the State's local social service districts are responsible for administering Medicaid, however, the job of designing and implementing this conversion falls to them. And, unlike Massachusetts, many of New York's social service districts are getting involved for the first time in widespread managed care. To allow districts time to do necessary planning, the legislature's mandate will be phased in over time. One-third of the 58 districts are slated to begin planning and implementation each November from 1991 through 1993. Under the plan, each district receives 6 months to submit a plan that enables the district to meet the following enrollment goals: 10 percent of clients at the end of the 1st year; 25 percent by year 3, and 50 percent by year 5. If all goes according to schedule, about 925,000 clients will be enrolled in managed care by the end of the decade.

**Philadelphia: HealthPASS.** Like their counterparts in other States, Pennsylvania Medicaid officials have expressed interest in introducing managed care options to the program. The State's relatively undeveloped managed care industry, however, makes immediate, wholesale changes in the program unlikely. Still, the State has successfully conducted a limited experiment in managed care for the past 5 years, and officials are singing the praises of this trial program, saying it saves upwards of \$12 million annually. This savings, moreover, has been realized with no apparent ill effects on access to health care or on quality.

Known as HealthPASS, the program was conceptualized in 1983, when a special cost-containment task force recommended that the State develop alternative Medicaid delivery systems that depart from the traditional fee-for-service model and make better use of marketplace incentives. The legislature

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followed up with funds to the Department of Public Welfare to enroll up to 10 percent of the Medicaid population, or about 100,000 people, in a demonstration capitation program. Recognizing that HMOs in the State lacked the capacity to enroll that many new subscribers, the Department contracted instead with a health insuring organization (HIO) to implement a primary care case management capitation program. Under this arrangement, a private firm contracts with primary care physicians and ancillary providers for services; helps recipients choose a case manager; resolves problems and complaints; administers benefits; processes claims; and monitors the use of services and quality of care. Armed with the necessary waivers from Federal Medicaid rules, the HealthPASS program started in March 1986. It now serves 81,000 people in west and south Philadelphia.

Unlike many HIOs that simply process claims, HealthPASS assists Medicaid recipients in choosing a physician (or a physician group or health center) to serve as their primary care case manager (PCCM). Clients must use these PCCMs as their first line source of care in all but emergency cases. In exchange, PCCMS receive a monthly per enrollee fee for services, including routine care, referrals to other physicians, and authorizations for hospital care and medical supplies. To ensure continuity of care, PCCMs must provide on-call, 24-hour-a-day service and be available at least 20 hours a week for office visits. The participating providers must also agree to enroll up to 300 Medicaid eligibles and take limited financial risk for some aspects of their care.

Half of the capitation payment goes directly to the PCCMs for their own services; the rest is put into a special referral fund and is used by the HIO to pay for other services for which they are at risk. At the end of the fiscal year, any balances in the fund are paid to the PCCMs, while any deficits are charged against their direct monthly payment. In theory, the monthly fee



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paid to PCCMs should be more than enough to cover both direct and indirect costs. The payment system, State officials say, was carefully constructed to encourage PCCMs to provide or arrange for all medically necessary services in the most timely, cost-effective manner.<sup>63</sup> If PCCMs over-refer or order too many tests, they lose money. At the same time, if they under-refer, patients eventually may need more care and at greater expense. And since the PCCMs share in any savings that derive from reduced use of hospital services, they have a strong incentive to use less costly resources whenever possible and to monitor admissions and lengths of stay closely.

### **Waivered Case Management Programs**

Section 2175 of the Omnibus Budget Reconciliation Act of 1981 authorized the Department of Health and Human Services to waive certain Medicaid provisions to encourage States to develop innovative health care delivery or reimbursement systems. The so-called "2175" waivers (often spoken of generally as "freedom of choice waivers") allow States to implement primary care case management programs, which restrict the providers from whom a beneficiary may receive covered services. (Such is the case with phase two of the Massachusetts initiative, known as the Primary Care Clinician Program.) Exhibit 3 indicates that some 827,000 Medicaid recipients or 35 percent of the managed care total are enrolled in waived (fee-for-service) case management programs, making it the largest type of managed care arrangement.<sup>64</sup> Twenty-five States have received freedom-of-choice waivers, up from 18 States in 1988.

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<sup>63</sup>Merritt, Richard E., "State of the Art: Pennsylvania," *State Health Notes*, Number 117, October 7, 1991.

<sup>64</sup>*Report on Medicaid Managed Care Enrollment*, op. cit.

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Congress considered the section 2175 case management experiments so successful that it added a provision to COBRA-85 that allows States to provide targeted case management as an optional Medicaid service without having to first seek a Federal waiver. The populations most often targeted are the chronically medically ill, the mentally retarded/developmentally disabled, and pregnant women. For example, Alabama has a case management program for high-risk pregnant women that has garnered much attention.

**Alabama: Providing Total Obstetric Care.** In September 1988, Alabama received Federal approval to establish a program of primary care case management for pregnant women. Under the program, primary providers must agree to assemble a network of maternity care providers from which enrolled clients receive all required obstetrics care. The primary provider must ensure that clients have adequate access to necessary specialty care and assist clients in using the established provider network. To complement the medical component of the program, maternity care coordinators act as professional client advocates, linking women with available social services within the community and providing nonmedical support services.

This coordinated and comprehensive approach to providing maternity care helps providers identify high-risk pregnancies early and encourages the development of individualized care programs that respond to the needs of each client. In turn, this early identification and response system prevents premature births and low birthweights, both factors that contribute to spiraling neonatal intensive care unit (NICU) costs. Early reviews suggest that Alabama's Maternity Waiver Program has resulted in decreased NICU

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expenditures, reductions in the number of hospital admissions for children younger than age 1, and a decline in the number of diagnostic testing.<sup>65</sup>

## **Preferred Provider Organizations**

PPOs are entities created for the express purpose of trading price discounts in return for greater volume. The typical PPO channels enrollees by making it less costly for them to use its panel of providers than to use other providers. For example, a PPO might offer a 20-percent discount to an employer; enrolled employees would have a 10-percent coinsurance payment if they used panel providers, compared to 30 percent if they used other providers.

PPOs have been established by half the State employee health benefit plans in this country. Of these, 17 use a point-of-service approach as part of an indemnity plan.<sup>66</sup> Some of the most recently established PPO networks are in Illinois, Maryland, Michigan, and West Virginia. West Virginia is an interesting case in point. In 1990, the State's Public Employees Insurance Agency projected a savings of \$8 million in health care costs through the introduction of a new PPO network. The PPO allowed the State to make payments based on a reasonable and customary fee schedule in which fees were limited to the level that 80 percent of the State's physicians charge. This initiative, as well as an effort to negotiate freezes in hospital charges for State employees, is the result of an attempt by the Governor to pay the State's debts to West Virginia physicians and hospitals.<sup>67</sup>

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<sup>65</sup>Alabama Medicaid Agency, "Focus on Maternal and Child Health," Press Packet, July 1991.

<sup>66</sup>Phone Conversation, Martin E. Segal Company.

<sup>67</sup>*Business Insurance*, August 21, 1989, p. 6.

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## Utilization Review

Since the mid-1980s, "utilization review" (UR) has become a familiar term in cost-containment jargon. Traditional fee-for-service plans have adopted the activity in an effort to impose at least some of the monitoring and channeling restrictions on beneficiaries that managed care programs offer by definition. Among the most common UR strategies used by commercial insurers and Medicaid alike are preadmission reviews for inpatient hospital stays; second surgical opinion for selected elective procedures; prior approval for a range of optional services and durable medical equipment; and routine reviews of provider practice and client utilization patterns.

Among State employee health benefit plans, for instance, a major development has been the introduction of precertification programs. According to analyses by the Martin E. Segal Company, 46 State plans have instituted some type of precertification or preadmission review program.<sup>68</sup> In several cases, the precertification programs include additional features such as hospital length of stay assignments, concurrent review, and discharge planning.<sup>69</sup> As private insurers, Blue Cross/Blue Shield, and State governments increasingly turn to these activities to contain rising costs, a whole industry has sprung up around UR.

Like any new industry, however, UR firms are being closely scrutinized—particularly at the State level—as legislatures discuss the need for regulation as a way to avert potential abuses and pitfalls. The industry's rapid growth—nationwide, an estimated 400 UR firms are now in business—and the growing volume of complaints have spurred debate in the States over

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<sup>68</sup>Martin E. Segal Company, *Annual Survey of State Health Benefit Plans*.

<sup>69</sup>Mackin, *op. cit.*



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whether Government ought to step in and regulate the firms or whether the industry is in a position to regulate itself. So far, the arguments for Government intervention seem to be prevailing. Before 1991, 15 States and the District of Columbia had moved to regulate UR firms. Over the last 6 months, the legislatures in another 24 States have conducted hearings on the UR industry with an eye toward standardizing and regulating firms operating within their boundaries. Of the total, eight have acted on laws—six dealing with the industry generally and two dealing specifically with reviews of substance abuse and mental health services.

### **Industry Standards v. Model Law**

In November 1990, the Utilization Review Accreditation Commission (URAC), an entity of the American Managed Care Review Association, issued national UR standards. The proposed standards specify that (1) the frequency of ongoing (but not daily) reviews for inpatient stays be determined by the patient's condition or by treatment and discharge planning activities; (2) written clinical criteria and review procedures must be available; (3) health professionals conducting reviews must be licensed in the United States; (4) determinations be made within 2 working days after necessary information is received; (5) initial notification of approved claims should be by telephone, followed by written notice to the treatment facility, physician, and patient within 2 working days and; (6) procedures for physician and patient appeals be specified. Using these standards, the commission has established an ambitious new program to accredit UR firms across the country.

Responding to the industry's proposal, the Legal Action Center, a public interest law firm in Washington, DC, is in the process of finalizing a model State UR law. The Center has recommended that (1) reviewers be required

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to have expertise in the areas of medicine they are reviewing; (2) patient placement and benefit criteria be published and accessible; (3) appeals be resolved similar to arbitration hearings; (4) patient-physician information be kept confidential; and (5) decisions be made promptly.

## State Responses

As the volume of bills introduced this year indicates, the States seem to believe regulation is needed. Of the States that enacted UR-related laws this year, six (Connecticut, Missouri, Montana, North Dakota, Oklahoma, and Texas) impose regulations defining the operation of UR firms. The six new laws have the following features in common:

- Providers and/or enrollees must be notified of a claims decision within a specified period of time, usually 2 days;
- A determination not to certify a service, admission, or procedure must be made in writing, with an explanation of the rationale for the decision and of the procedures for initiating an appeal;
- UR firms have 30 days in which to respond to an appeal and the appeals must be decided by a physician;
- Companies must have an expedited appeals process of no more than 2 business days to deal with emergency or life-threatening situations;
- Companies must evaluate and periodically update their written criteria and review procedures and maintain strict confidentiality of records;



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- Firms must disclose qualifications of the review personnel they hire;
  - Review agents must be accessible 5 days a week during normal business hours; and
  - Fines will be assessed for violating any of the above provisions.

Physicians, hospitals, and clients have argued that UR personnel who review claims and decide appeals are not qualified to do so. The legislation enacted in Connecticut and Missouri specifically addresses this issue by requiring that a physician or relevant specialist be involved in making decisions on appeals. In North Dakota, the law states that UR determinations must be reviewed by a physician or psychologist. Montana, Oklahoma, and Texas also enacted laws that call for a physician to be involved in the appeal process.

On the other hand, UR firms oppose requirements to publish standards and procedures and argue there is no need for external evaluations of procedures or standards. None of the laws enacted thus far give the Department of Health or the Commissioner of Insurance responsibility or authority to review, comment, or evaluate on a plan submitted by a UR firm. The new laws in Connecticut, Missouri, and Oklahoma require UR firms to make summaries of their standards available to the public.

In addition to the six new laws imposing industry-wide regulations, two other 1991 UR laws in Hawaii and Minnesota relate specifically to mental illness or drug and alcohol abuse. These two specialty areas account for a growing share of the health insurance dollar and, as a result, have caught the eye of employers (and insurers) who must pay the bill. Hawaii's law directs the Health Department to develop regulations to be used by all UR firms in

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reviewing services or admissions for mental health and substance abuse treatment. Minnesota's legislature amended the State's current UR statute to require that someone who has experience in the field of chemical dependency (the law lays out the qualifications) review claims for services.<sup>70</sup>

## Planning

Health planning and certificate of need (CON)—two companion programs that fell into disfavor during the antiregulatory, free-market mood that dominated the 1980s—are experiencing a resurgence of interest of sorts at the State level. Renewed interest in traditional regulatory vehicles comes as lawmakers cast about for solutions to two of the most pressing concerns in today's health arena: out-of-control costs and deteriorating access to care.

Enacted in 1974, the health planning act was seen as a key weapon in the Federal Government's cost-containment arsenal. Local planning agencies that sprang up across the country were the heart of the law, and CON—the tool by which States could veto costly building projects and equipment acquisitions proposed by health facilities—was its teeth. Between 1986 and 1989, after Congress repealed the planning act (PL 93-641), many States scaled back. In the wake of the repeal, which also spelled the end of Federal funds to support planning efforts, 11 States also repealed their CON review programs, while 5 others deregulated hospitals and other acute care services. Most States, however, took a more moderate approach, streamlining programs, deregulating services and providers—particularly those perceived as not contributing to long-term health care cost increases—and raising expenditure threshold levels to exempt all but the most costly projects.

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<sup>70</sup>Research for this section was conducted by Lee Dixon, IHPP Deputy Director.

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Over the past 2 years, however, several States have begun to consider strengthening their CON laws and reintegrating the planning process into other health care reforms under debate in the legislatures. The following paragraphs profile just some of the planning initiatives that have recently come to the fore.

## **State Profiles**

**Georgia: Major Changes in CON.** In 1989, Georgia's legislature created a 29-member Commission on Access to Health Care, charging it with identifying the barriers that interfere with access to the health system and recommending corrective strategies. The Commission's report, released in December 1990, also offered a range of recommendations designed to control costs and provide equitable financing, including strengthening and broadening the powers of the State Health Planning and Development Agency (SHPDA) and the CON program to reduce unnecessary duplication of services. It also emphasized the need to tighten control over all the factors leading to increased costs, including those that affect "infrastructure" costs.

Specifically, the Commission recommended (1) revising the statutory definition of "clinical health services" to remove facility-based exemptions, thereby bringing the development and expansion of all services covered under CON under the purview of the law (regardless of the provider's location or legal structure; (2) strengthening the enforcement powers of the SHPDA; (3) raising expenditure thresholds; (4) requiring providers to release ownership information; (5) tightening criteria for acquisitions; (6) amending the SHPDA's authorizing legislation to place greater emphasis on comprehensive planning for the State's primary, secondary, tertiary, and long-term health care needs; and (7) establishing a "batching" process for reviews of specified types of projects.

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The legislature responded by enacting four new laws during the 1991 session—the most comprehensive changes in the State's CON process since 1983 when the original law was completely rewritten:

- HB 508 broadened the requirement for obtaining a CON to include physicians' and dentists' offices and freestanding diagnostic, treatment, and rehabilitation centers that offer specified services (e.g., cardiac catheterization, diagnostic imaging, and biliary lithotripsy). Fines for operating without a required CON were hiked from a maximum of \$500 a day to \$5,000 for each day an infraction continues.

The act also minimally raised the thresholds for review, from \$496,993 to \$500,000 for major medical equipment and from \$886,835 to \$900,000 for capital expenditures. (Review thresholds will continue to be indexed annually to reflect changes in the Composite Construction Index.)

- SB 192 replaced the Health Policy Council with a new "Health Strategies Council." The new council has the same number of members, but its composition and functions have changed. Membership now includes 10 providers, an equal number of consumers plus representatives of the insurance industry and county government. The strategies council will also be more involved with issues that particularly relate to access. For example, it has been charged with evaluating the State's health care resources and their availability, patient costs, and quality, with an emphasis on involvement by all relevant State agencies.

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- SB 209 required health facilities to notify the planning agency within 45 days after making an acquisition; late notices may result in a \$500 fine. (Public facilities that acquire other public facilities are exempted from the rule.) The measure also authorized the SHPDA to implement "batching" procedures for three categories of services: skilled nursing care, intermediate nursing care, and home health care. Finally, it established fines for facilities that fail to meet indigent care obligations specified as part of the CON approval process.
  - HB 546 revised an amendment enacted during the 1990 session regarding the revocation of a CON held by facilities that lose their operating licenses. The measure provided that forfeiture of a CON becomes operative 180 days after the date for filing an appeal of a revocation order. If the facility appeals the decision and loses, the revocation becomes effective on the expiration date for appealing the order supporting the revocation.

**Oklahoma: Expanding CON.** A new Oklahoma law (HB 1742) requires substance abuse and chemical dependency treatment beds for children and adolescents under age 18 to obtain a CON, regardless of their licensed bed size. Previously, facilities with fewer than 120 beds—the category into which most facilities in the State fall—were not required to have a CON. The law was part of a package of four bills designed to curb overutilization of adolescent inpatient psychiatric hospital beds as well as to improve the State's overall mental health and substance abuse treatment services for children.

**Delaware: Medical Equipment.** Delaware's legislature has also has taken steps to reinforce the health planning process, one of which is specifically designed to tighten the provisions governing major medical equipment and



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CON review requirements. HB 162 restructures the categories of facilities regulated under the CON law to more closely reflect the licensure categories used by the Board of Health. Planning officials in Delaware have indicated that the changes reflect new types of facilities that have been developed over the past 5 to 10 years, including birthing centers, freestanding emergency centers, and ambulatory surgery facilities. The law also (1) expands membership on the Health Resources Management Council from 15 to 18; (2) prohibits members from voting on issues that represent a conflict of interest; and (3) authorizes the council to approve exemptions of acquisitions of health care facilities from review requirements.

Perhaps the most significant change in the CON law enacted this year is that any piece of major medical equipment used for diagnostic or treatment purposes that trips the capital expenditure threshold of \$750,000 will now be subject to review, regardless of location. Two other provisions may bring additional types of equipment under CON review as well. One gives the Health Resources Management Council authority to subject equipment to CON review requirements regardless of the capital costs involved. Medical technology that has not yet been disseminated across the State will also be subject to review, unless specifically exempted.

**Omnibus Florida Health Bill.** Efforts to reform Florida's health care system this year led to passage of an omnibus bill (SB 1000) that incorporated provisions from at least nine other measures, several of which relate to the CON program and health planning process. One of the provisions that survived last-minute changes increases health facility licensure and CON and health planning fees. The increases, estimated at \$9 million, are intended to completely fund the CON review process. Capital costs involved in refinancing were deregulated from review, but attempts to raise the capital



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expenditure review threshold to \$5 million failed, along with deregulation of cardiac catheterization services.

The most controversial issue in the debate involved an existing exemption from the CON process for HMOs. In the final version, hospital projects undertaken by HMOs will need approval, except those that received an exemption by April 17, 1991. The grandfather clause was designed to keep the legislature out of a lawsuit involving Humana, which is seeking an exemption from CON to establish a variety of tertiary care services, and the Department of Health and Rehabilitative Services, which had turned down the firm's request. The hospital industry backed outright repeal of the exemption provision.

**Changes in Virginia's COPN.** Current changes in Virginia's Certificate of Public Need (COPN) program reflect recommendations of a 1990 commission report urging the legislature to retain the program as a mechanism to improve access. This year, for example, the legislature approved HB 1331, extending a moratorium on all new nursing home beds for 2 more years. The moratorium, instituted initially in 1988, had already been extended twice, in 1989 and 1990. A July 1, 1991, sunset provision for regulation of hospitals and ambulatory surgery centers under COPN was also delayed for 2 years while the Health and Human Resources Department studies the expected impact of the proposed repeal. HB 1331 also:

- authorizes the Board of Health to establish a fee schedule for applications to finance COPN. Fees may not exceed the lesser of one-half of 1 percent of the proposed capital expenditures, up to \$5,000;

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- establishes registration requirements and confidentiality protections for information submitted to the Commissioner of Health relating to new clinical services, acquisition of major medical equipment, and projects that require COPN review with a capital expenditure over \$400,000 as well as projects that do not require review but cost over \$1 million;
  - authorizes the Board of Health to create a structured "batching" process; and
  - provides that the granting of a certificate may be conditioned on an agreement by the applicant to provide a level of care at a reduced rate to the poor or accept patients requiring specialized care.

**West Virginia Lowers Review Thresholds.** West Virginia also strengthened CON, lowering expenditure review thresholds and thereby bringing more projects and services under review. The new thresholds set by HB 2194 are (1) \$750,000 for capital expenditures (down from \$1 million); (2) \$300,000 for major medical equipment (down from \$750,000); and (3) \$300,000 for operating expenses for proposed new services (down from \$500,000). The changes relate at least in part to the bankruptcy of the State's Blue Cross and Blue Shield plans. The rate setting authority has also been given the responsibility of developing a new methodology and investigating other cost containment proposals.

## **Sunset Reviews/Repeals of CON**

CON programs in several States were scheduled for sunset review and repeal this year, but to date, most efforts to extend them have been successful. For example, Ohio's CON program—scheduled for sunset review in

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November—has been the subject of a 2-year evaluation process. A draft report has been released, and a final report is expected by the end of the month. The report's strongest criticism was that lack of consensus on the goals of the CON program has produced only marginal results for the CON efforts. While not advocating outright repeal, the report stresses the need to change the process. State officials, however, indicate that there is not a ground swell of support for repeal at this time. A bill introduced to provide for repeal in another 2 years will probably become the vehicle for proposals to change and strengthen the current program.

In Indiana, the CON program, which regulates only long-term care beds and services, was scheduled to be repealed in July. Governor Bayh vetoed a bill (SB 182) to extend the program until 1993, but in a special budget session, the legislature reinserted the 2-year extension into the budget bill (HB 1001); Bayh signed it on June 14. A separate provision sets up a long-term care Medicaid and CON study committee, with a report due by the end of the year.

West Virginia lawmakers extended the Health Care Cost Review Authority, which was scheduled for sunset review this year, until 1997. Tennessee's Health Facilities Commission has also been granted a 1-year extension, and Montana's CON program, scheduled to be repealed this past July, has been indefinitely extended.<sup>71</sup>

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<sup>71</sup>Research included in this section was conducted by Connie Thomas, a senior research associate at IHPP.

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## Expanding Revenue Sources

Even with aggressive cost control programs in place, many States are still watching as their Medicaid budgets rapidly increase. Short of cutting back on important services or closing out clients who are medically needy but not categorically eligible for the program, these States have been forced to develop new or build on existing revenue sources. One strategy in particular, provider-specific taxes, is receiving attention— at both the Federal and State levels. These assessments trace their roots to an earlier financing source, provider donations, that has since fallen into disfavor with Federal officials.

States are turning with increasing frequency to provider taxes as an untapped source of additional Medicaid funds. Earmarked assessments offset general fund expenditures for Medicaid and are reflected in the States' share of Medicaid costs. As a result, Federal funds to match the States' contribution increase. This method for expanding State Medicaid revenues has enabled States to:

- maintain existing coverage levels,
- fund necessary program expansions, and
- avoid reductions in already low provider reimbursement rates.

According to the Department of Health and Human Services Inspector General's report, 18 States have already implemented tax or donation programs to supplement State Medicaid funds.<sup>72</sup> Some estimates put at 35 the number of States that rely on assessments for some portion of Medicaid

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<sup>72</sup>HCFA & OMB, *op. cit.*

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revenue.<sup>73</sup> Efforts in Kentucky and Alabama, where assessment programs are thriving, demonstrate the important role these programs can play in financing Medicaid services.

### **Kentucky: Expanding the Tax Base**

In July 1990, Kentucky launched its initial provider assessment initiative. The project, known as the Hospital Indigent Care Assurance Program (HICAP), targeted disproportionate share hospitals for supplemental payments and financed these payments through a 1-percent tax on all hospital operating costs. State officials say these hospital taxes helped avoid "drastic cuts" that had been slated for the program and speculate that the planned service reductions would have translated into people going without treatment.<sup>74</sup> Recognizing HICAP's early success, the legislature this year enacted HB 21 authorizing assessment programs targeting a range of providers, including physicians, nursing homes, pharmacists, and mental health centers.

### **Alabama: Using Taxes for Expansion**

Like Kentucky, Alabama has turned to provider taxes to enhance State Medicaid funds. The State has used revenues from these assessments not only to maintain current services but also to expand Medicaid in a number of critical areas. Among the program changes implemented October 1 are increases in:

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<sup>73</sup>American Public Welfare Association, Medicaid Management Institute, "Summary of Provider-Specific Tax Programs," September 1991.

<sup>74</sup>Wessner, Connie, "HCFA Publishes Matching Regs," *State Health Notes*, Number 118, October 21, 1991.

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- hospital inpatient coverage from 14 to 16 days,
  - the number of physician office visits from 12 to 14 per year,
  - the number of physician inpatient visits from 14 to 16, and
  - nursing home reimbursement to include more direct nursing care.

Alabama's assessment program has received full support from the State's hospital, pharmacy, and nursing home associations—the three provider groups targeted by the new tax.

## **Following the Assessment Lead**

Taking their cues from existing assessment programs, the Minnesota legislature and the Texas comptroller's office have supported proposals that reflect mounting confidence in provider taxes as a means of financing Medicaid services. Minnesota law established surcharges for hospitals, nursing facilities, and health plans effective July 1, 1991. Revenue generated by the surcharges is designated for Medicaid and will help fund rate increases for nursing facilities, hospitals, physicians, dentists, and health plans. The law also authorized cost of living increases in the personal needs allowance. Citing assessment programs in Kentucky, Arkansas, Maryland, and Florida, the Texas Performance Review recommends expanded use of the State's disproportionate share program.

Provider-specific taxes also played a lead role in the legislative agendas of at least seven additional States (Mississippi, Montana, Nevada, New Hampshire, New Jersey, Vermont, and Washington) this year. In some cases, these taxes targeted only hospitals and long-term care facilities. Many legislatures,



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however, approved broader based taxes that included providers such as physicians, pharmacies, home health agencies, and community health centers.

**Federal Response.** Under a Bush Administration proposal set to begin in 1992, however, States will no longer receive matching funds<sup>4</sup> for Medicaid expenditures financed by voluntary contributions and provider-specific taxes. The proposed regulations, moreover, appear to at least limit a longstanding State practice of using transfers from public hospitals and other agencies to finance Medicaid-covered services. By some estimates, the Administration proposal could cost 35 States upwards of \$3 billion. The recent controversy surrounding State Medicaid expenditures is the latest chapter in a story that began back in February 1990 when HCFA first published its proposal in the *Federal Register*. HCFA's stated intention was to limit Federal matching funds to "net [State Medicaid] expenditures." Although somewhat ambiguous, this limitation represented a departure from previous HCFA rules allowing States' use of private funds for Medicaid and prompted a congressional moratorium on implementation of the new regulation.

That moratorium, however, is slated to expire at the end of this year, and its renewal remains unlikely. Spurred on by a recent HHS/OMB study investigating spiraling Federal Medicaid costs, HCFA has republished its proposed regulations with an implementation date of January 1, just after the moratorium expires. With this change in Federal cost-sharing only 3 months away, both the States and Congress are expressing rising concern over the Administration's commitment to the Medicaid program. For example, California's recently enacted program of local fund transfers to Medicaid may be in jeopardy. Because of their reliance on Medicaid to finance health care costs, Southern States stand to lose the most if HCFA's regulations are

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implemented. Henry Waxman has suggested "there is a good chance that some of these programs [in the South] may collapse by next spring." <sup>75</sup>

**Congressional Response.** Attempting to deflect yet another blow to State budgets, Members of Congress are gearing up for a possible legislative battle with the White House over HCFA's proposal. Thus far, at least two bills (HR 3550 and HR 3595) to block the regulations have been introduced. With support for legislation building on both sides of the aisle, the debate now turns to OMB's savings projections. Waxman raised the issue in his letter to Darman, citing a February 1991 OMB projection putting the FY 1992 savings at \$80 million.<sup>76</sup> In the months since that initial projection, Administration officials at HCFA and OMB have offered various estimates ranging from \$1 billion to \$4 billion. With the January 1 effective date rapidly approaching, there remains no definitive answer to how the proposed regulations will affect State Medicaid programs. HCFA has issued a clarification of the rules published in September, and negotiations between Congress and the White House continue.

## Cost-Shifting

With long-term care costs continually rising, more and more elderly people, who would otherwise be considered middle-income couples, must turn to the Medicaid program to finance necessary institutional care. Options to help these couples remain in their homes and in the community longer are growing but not fast enough to provide competition to and reduce the costs of more traditional institutional care. As a result, some States are beginning

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<sup>75</sup>Wessner, *op. cit.*

<sup>76</sup>Waxman, Henry. Letter to Richard Darman. October 8, 1991.

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to experiment with public-private insurance partnerships to help elderly individuals get the care they need without impoverishing themselves while also partly controlling Medicaid outlays for such care.

Four States are poised to go forward with initiatives of this kind. The aim is to give people a financial incentive to buy a State-certified private plan by promising to protect a larger share of their assets if, at a later time, they must apply for Medicaid. The States involved—Connecticut, Indiana, New York, and California—are survivors of a group of eight States awarded grants by the Robert Wood Johnson Foundation (RWJF), beginning in 1987, to develop model "public-private partnerships" for financing LTC insurance coverage. Three original grantees (Massachusetts, New Jersey, and Oregon) have decided, for differing reasons, not to go beyond the planning phase, and implementation in Wisconsin appears doubtful.

Contrary to popular assumptions, Medicare offers almost no coverage of long-term care services, save for limited home care and hospice benefits. Medicaid, on the other hand, does cover institutional nursing care but only after recipients have spent all but a few thousand dollars of their resources and have, de facto, impoverished themselves. In addition to the gap in public coverage, commercial insurers until recently have shown little interest in developing the LTC market. Several bottom-line reasons explain their reluctance to get into the market, including fears of (1) adverse selection, (2) demand spurred by the availability of such insurance, and (3) open-ended liability. Questions about how to price policies and about the capacity of policyholders, many of whom are or will soon be on fixed incomes, to pay monthly premiums also figured into the equation. Marketing plans to younger customers has also been seen as a no-win venture, since even people who are nearing retirement age tend not to focus on the likely need for long-term nursing care down the road.

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Recognizing the gap in program and actuarial experience in the LTC insurance arena, RWJF made 2-year planning grants available to States interested in investigating the potential role of public/private partnerships in financing insurance plans. Although the planning strategies and participation standards of each of the eight States awarded the grants varied, their goals are similar: to encourage people who can afford to buy a private LTC policy to do so. In exchange, the State promises to protect their assets when the policy expires by coordinating with Medicaid. In sum, for every \$1 a policy pays out for Medicaid-covered services, the State shields \$1 in assets from Medicaid "spend down" rules.

Originally, the implementation strategies hinged on receiving a waiver from Federal Medicaid rules, and for a time it appeared Congress would go along with language granting waiver authority. Both the House and Senate had approved a provision to that effect but dropped it during conference on OBRA-90 last October. As a result, the States pursuing implementation have shifted gears and are now seeking approval of Medicaid plan amendments from the Health Care Financing Administration (HCFA).

Connecticut filed its plan amendment in late May; on August 28, right on schedule, it received HCFA's okay to proceed with its Partnership for LTC, clearing the way for implementation. The State had already procured a 3-year, \$1.8 million grant from RWJF to proceed and has statutory authority to market the LTC policies on a statewide, voluntary basis. Earlier this year, Partnership officials estimated that the five participating insurers would sell 50,000 policies in the first 5-year period. In addition, the Partnership will set standards that are more restrictive and consumer oriented than those governing commercial plans.



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Indiana submitted its State plan amendment in June. Like Connecticut, its goals are to offer quality, affordable insurance, contain the growth in public expenditures, and foster better public understanding of the market. The foundation has awarded the State \$1 million over 3 years to implement its LTC plan, pending HCFA's approval. In September, a task force will reconvene to draft a set of minimum standards to cover policies offered through the partnership project, although officials will wait for HCFA's approval of the plan amendment to promulgate final rules. Policies governing nursing and home health benefits could be on the market 90 days after HCFA acts.

New York has already been given a 3-year, \$1.7 million grant from the foundation to implement a statewide LTC plan but will wait until late September, after the outcome of Connecticut's bid is known, to submit a State plan amendment. The goal is to sell policies to 100,000 elderly residents in the first 6 years, and plans are on the market. Concurrently, the legislature has before it a bill to create a State-only LTC insurance program not tied to Medicaid. The bill, which would offer tax credits to people who buy LTC insurance, has not advanced this session because of the distraction of budget problems. Backers say it will be revived in 1992.

Of the eight original grantees, three dropped out after the planning phase. Massachusetts did so in May, citing the State's overwhelming budget problems. New Jersey quit after Congress failed to grant waiver authority; a State plan amendment was not deemed a practical alternative, an official there said. And Oregon project officials were unable to devise a plan that would have been compatible with the foundation's standards and the State's

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own long-term care system, which emphasizes home and community-based care over nursing home care.<sup>77</sup>

## Selective Contracting

As with many of the other cost-containment strategies profiled in this paper, selective contracting is a tool with which many State Medicaid programs are experimenting. IHPP's original cost-containment report included information regarding limited selective contracting initiatives in the States. The information is included again in this section; no updated information has been compiled since the report was written in early 1990. In addition, this section contains profiles on selective contracting efforts in California and Arizona. More detailed descriptions of these initiatives are provided for two reasons: (1) More recent data have been received on California's contracting program for inpatient hospital services, and (2) the Arizona Health Care Cost Containment System (AHCCCS) has been touted as a national model. Although AHCCCS emphasizes managed care, its profile is included here rather than in the report's managed care section because, unlike other States where traditional fee-for-service systems exist side by side with managed care arrangements, AHCCCS is the State's Medicaid program.

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<sup>77</sup>Demkovich, Linda. "Focus On....Long-Term Care Insurance," *State Health Notes*. Number 116, September 1991.

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## Volume Purchasing Arrangements<sup>78</sup>

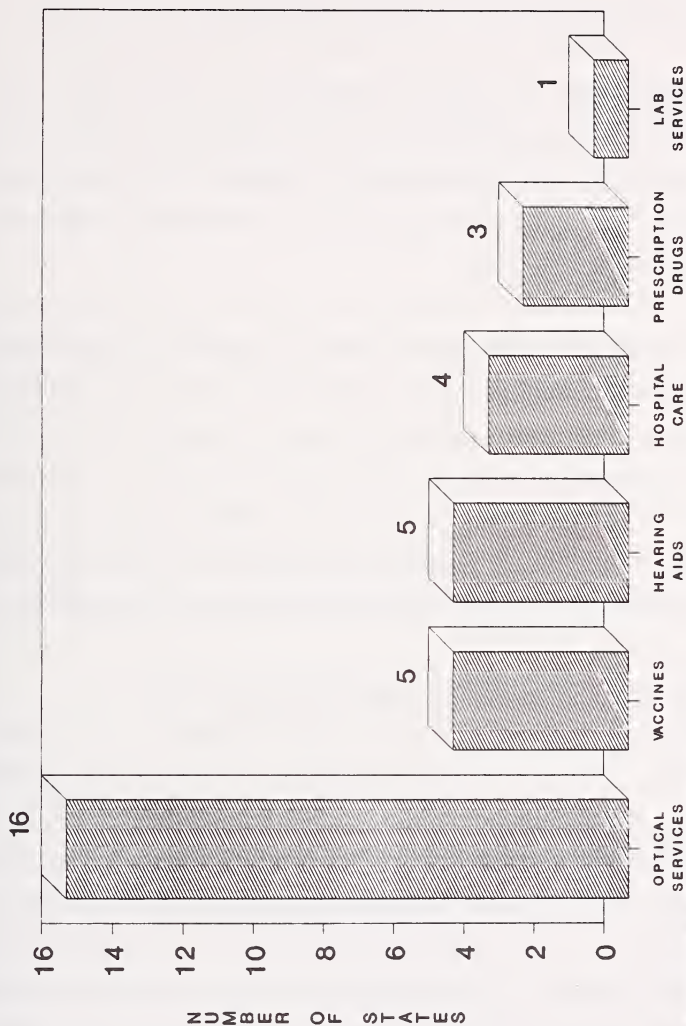
A growing number of States use competitive bidding programs to purchase Medicaid-covered health care services. Exhibit 4 shows the range of services purchased through these arrangements by State Medicaid programs. For example, the most recent available data indicate that 16 States use some type of volume purchase arrangement for providing optical services to Medicaid clients. Providers selected through these arrangements may serve as the sole source of the items covered, or other providers not covered under the terms of these agreements may offer the service only by meeting the price of the contracted providers. A more specific example of volume purchasing for Medicaid services comes from Ohio, where the Department of Human Services has negotiated with two large optical laboratories to provide eyeglasses. Some estimates have suggested that this arrangement saves the State \$1 million annually on coverage of eyeglasses.

Another example of volume purchasing comes from States that negotiate with pharmaceutical companies or the Federal Centers for Disease Control (CDC) to purchase vaccines for Medicaid-eligible children. Current data indicate that only five States (Illinois, Louisiana, Nebraska, New Hampshire, and Ohio) use this type of arrangement. Before moving to this volume-purchasing strategy, Ohio, for instance, paid physicians for both the cost of administering vaccines and the costs of purchasing these vaccines. An agreement with the CDC, however, now allows Ohio to purchase vaccines at below-market prices for all of its Medicaid-eligible children. In FY 1989, the State estimated that savings from the CDC agreement would total \$1.4

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<sup>78</sup>Laudicina, Susan, *Cost Containment in Public Health Programs*, prepared for the Health Care Cost Containment Board, Florida Department of Health and Rehabilitative Services, published by IHPP, March 1990.

# EXHIBIT 4 COMPETITIVE BIDDING - BULK PURCHASINGARRANGEMENTS UNDER MEDICAID



Based on data from the Medicaid Source Book: Background Data & Analysis, Congressional Research Service, 1988

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million, a 50 percent reduction in expenditures under the previous system.

Other examples of limited competitive bidding efforts follow:

- Through March 1990, three States (Arizona, Georgia, and Kansas) had established competitive bidding programs for purchasing prescription drugs. In Kansas, the State accepted bids on 6 of the 30 drugs planned for inclusion in the contracting program.
- Nevada uses a competitive bidding approach for purchasing laboratory service under Medicaid. For the past several years, the State has saved a significant amount using two sole-source laboratories.
- Minnesota and Washington have sole-source contracts for oxygen. Minnesota also has a sole-source contract for wheelchairs.

### **California: Purchasing Inpatient Services**

Since 1982, officials at MediCal, California's Medicaid program, have been at work piecing together a comprehensive system of selective contracting for inpatient hospitals. Nearly two-thirds of the inpatient facilities participating in MediCal, 237 California hospitals, had signed contracts with the program by January 1991. With the exception of two hospitals, all of these contracted facilities are located within "closed areas" where contracted capacity is sufficient to limit client access to only those facilities in the selective contracting program. According to MediCal's estimates, 86 percent of all inpatient expenditures (excluding acute psychiatric care) went to hospitals within the contracted system.

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In January 1991, the California Medical Assistance Commission released a report evaluating the impact of this shift to contracted inpatient care. A summary of the chief indicators that were discussed in the report follows:

- Since 1988, the total number of participating hospitals has remained at 237, despite some turnover in participation. According to the report, MediCal officials have successfully let several new contracts and renewed enough previous agreements to offset any terminations from the selective contracting program.
- For the 237 participating hospitals, bed capacity exceeds 100 percent of estimated need for six critical areas of care: med/surg ICU, pediatrics, obstetrics, ICNN, burn center, and acute rehab.
- Estimated 1991 savings as a result of the selective contracting program totals approximately \$400 million. According to the Commission report, the 1991 savings estimate is double the original savings estimates calculated at the program's inception in 1982.<sup>79</sup>

## **Arizona: Providing Medicaid Services Under the Managed Care Umbrella**

As recently as 10 years ago, Arizona remained the only State that did not offer a Medicaid program for low-income families and individuals. The State's entry into public health care coverage in 1982, moreover, represented a sweeping departure from the way States traditionally structured their Medicaid and indigent care programs. Instead of adopting the fee-for-service approach made popular by other States, Arizona officials developed a state-

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<sup>79</sup>California Medical Assistance Commission, "Annual Report to the Legislature," January 1991.

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wide contracting system to provide care only through the most competitive managed care plans available in the State. Now, 10 years after its creation, the Arizona Health Care Cost Containment System (AHCCCS) serves more than 330,000 clients.<sup>80</sup>

AHCCCS was initially administered by a private contractor but doubts about the contractor's effectiveness, signaled primarily by administrative and budget problems, led to the termination of the private contract in 1984. At that time, the State took over administration of the program and continues to manage AHCCCS. Quality control reviews, as well as contract compliance audits were conducted by Arizona in 1984 and led to the introduction of new management information systems and the termination of insolvent health plan contracts. Since then, AHCCCS has continued to grow and strengthen and remains the only statewide prepaid Medicaid system in the country.<sup>81</sup> Under its 1115 Federal waiver, Arizona receives Federal matching funds based on prepaid capitation estimates rather than per client, per service expenditures. The 1115 waiver, however, also requires that Arizona assume all financial risks for containing costs.

Two years ago, both the Flinn Foundation and SRI International undertook evaluations of AHCCCS. Both evaluations were cautious but positive about the program's impact on clients and on costs. According to SRI's January 1989 report, AHCCCS costs "averaged 5 percent less than our estimates of a traditional Medicaid program in Arizona" in the first 5 years.<sup>82</sup> Moreover, SRI concluded that a range of additional outcome indicators suggested that care received under AHCCCS was "at least as good as that provided by

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<sup>80</sup>AHCCCS, "Arizona's Health Care Program for the Indigent: Overview," Updated December 1990.

<sup>81</sup>AHCCCS, *op. cit.*

<sup>82</sup>McCall, Nelda, et al. "Evaluation of the AHCCCS," SRI International, January 1989.

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traditional Medicaid." <sup>83</sup> In terms of client satisfaction-a rare commodity for most Medicaid programs-the Flinn Foundation report provides evidence that Arizonans are happy with the unconventional program. "There is a consistent message: for every adult enrollee who found access to his former provider easier, three enrollees said access under AHCCCS was easier. For each adult enrollee who preferred the care of his previous provider, three enrollees preferred the care of AHCCCS providers. For every adult enrollee dissatisfied with AHCCCS, 13 are completely satisfied." <sup>84</sup>

## Prospective Reimbursement Systems

The past decade has witnessed a striking evolution in the way Medicaid reimburses institutional providers of health care services. While cost-based retrospective payment systems once ruled, they have now become the exception (see Exhibit 5). Prospective payment systems of one type or another now regulate the vast majority of Medicaid expenditures for inpatient hospital care, skilled nursing services, intermediate care facilities, and a growing share of home health services.

In the interest of clarity, it should be kept in mind that retrospective reimbursement systems may contain prospective elements (e.g., target rate ceilings set in advance), just as prospective systems may include retrospective features (e.g., projected inflation allowance adjusted for actual inflation). The essential difference between the two payment models is that retrospective systems allow a final cost settlement at the end of a provider's

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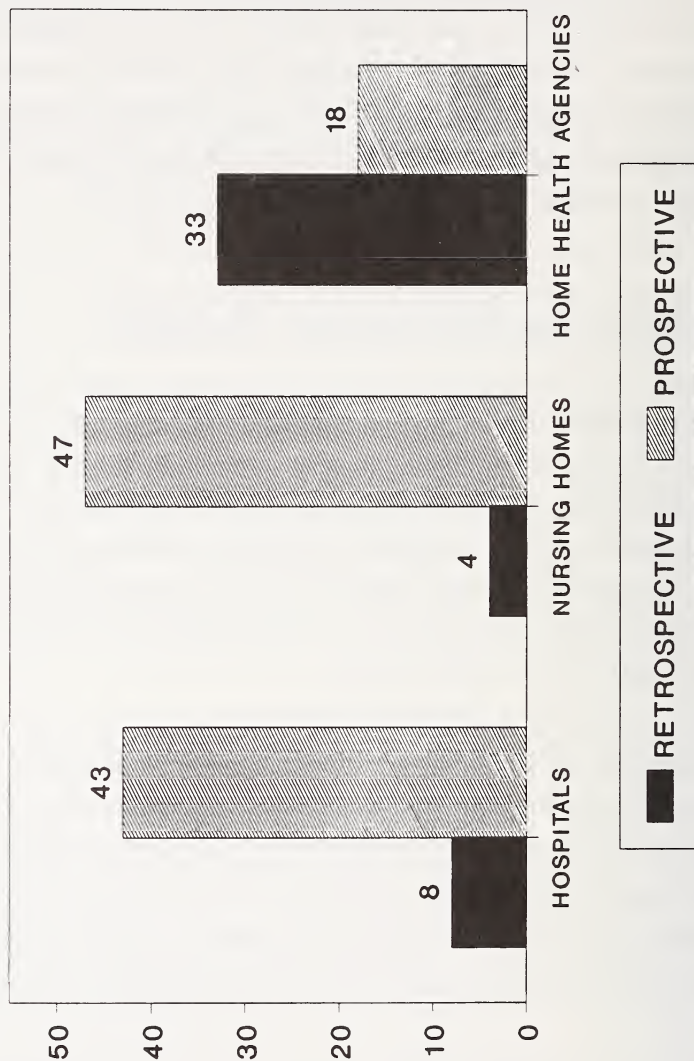
<sup>83</sup>McCall, op. cit.

<sup>84</sup>Arizona State University School of Health Administration and Policy, "AHCCCS in 1989: A Progress Report," published by the Flinn Foundation, 1990.

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# EXHIBIT 5 CURRENT MEDICAID REIMBURSEMENT SYSTEMS



SOURCE:  
Intergovernmental Health Policy Project

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fiscal year to account for actual experience, whereas prospective systems do not.

The most widespread Medicaid hospital reimbursement system, used in 20 States, is one that applies prospective rate of increase controls to allowable base-year costs. The next most prevalent system and the one that has experienced the greatest growth during the 1980s is the prospective case mix model. At present, 18 States employ a case mix payment system based on Medicare diagnosis-related groups (DRGs) or State-developed classification schemes of illness. This number will grow, as New Mexico and Wisconsin are currently developing their own DRG-based strategies. (Another type of prospective payment methodology, selective contracting, was examined in the previous chapter.)

The most definitive evaluation of prospective versus retrospective hospital payment systems to date employed multivariate analysis to determine the effects of alternative Medicaid reimbursement policies on hospital revenues from 1980 to 1984. It reached the following conclusions:

- Medicaid programs benefit substantially from all-payer systems. While most Medicaid-only prospective systems were successful in controlling hospital revenues relative to costs and in achieving Medicaid discounts, they were not as successful as the all-payer systems in affecting levels of revenues per day and per admission;
- Most types of Medicaid-only systems were very successful in controlling revenues relative to costs. However, only those with strong efficiency incentives (i.e., those where the payment system is only rebased every 2 years or more) were as successful as the

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all-payer States (Maryland, Massachusetts, New Jersey, and New York) in controlling the absolute level of per diem payments to hospitals; and

- 3) The Medicaid-only systems had a substantial one-time reduction in growth in spending in the first full year of implementation. After that, they did not have significantly different growth rates than retrospective hospital reimbursement systems.<sup>85</sup>

As far as Medicaid payment for nursing home care is concerned, the most prevalent prospective reimbursement model is one that pays a flat rate per diem, adjusted for inflation, either by individual facility or class of facilities (38 States). In nine other States, the actual prospective rate is determined through application of a patient case mix classification system.

Empirical evidence is not yet conclusive, and more research needs to be performed. Nonetheless, it would appear from the results of several studies that States with flat rate systems have lower rates of increase in costs than other States, while those with prospective nursing home payment systems generally have lower rates of increase than States with retrospective systems.<sup>86</sup> However, there are many important exceptions to these general findings. For example, while flat rate systems inherently contain strong incentives, the method for establishing and adjusting the rate is very important. Prospective systems can achieve low rates of increase, but their

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<sup>85</sup>Zuckerman, S. and Holahan, J., "PPS Waivers: Implications for Medicare, Medicaid and Commercial Insurers," *Journal of Health Politics, Policy, and Law*, Vol.13, No. 4, Winter 1988.

<sup>86</sup>Holahan, J., "State Rate Setting and Its Effects on the Cost of Nursing Home Care," *Journal of Health Politics, Policy, and Law*, Vol. 9, No. 9, Winter 1985; Swan, J. and Harrington, C., "Medicaid Nursing Home Reimbursement Policies," *Long-Term Care of the Elderly*, Sage Library of Social Research, 1985; and University of Southern Maine, "A Longitudinal Study of the Impact of Medicaid Prospective Reimbursement on Nursing Home Care in Maine," U.S. Health Care Financing Administration, 1988.

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success depends very much on the nature of the inflation adjustments, percentile ceilings, efficiency incentives, and base adjustments used. In addition, while retrospective systems can be potentially disastrous for cost containment, some States have shown that the undesirable inherent incentives can be offset by the proper application of efficiency incentives and/or low percentile ceilings.

Compared to payment for hospitals and nursing homes, Medicaid agencies have not experimented with new home health reimbursement systems to a significant degree. A majority of States still pay for home health services using traditional Medicare cost-based principles. Of the 18 States employing prospective payment for home health agencies, half have established prospective rates with ceilings and half-use fee schedules. Presently, no empirical research has been conducted to assess the cost-effectiveness of these prospective systems.

There was not much activity to reform Medicaid provider payment systems during the 1989 State legislative sessions. The two significant exceptions are New York and Washington, where initiatives to enact universal health coverage and, at the same time, achieve cost savings were given serious consideration. New York's plan, which is being developed by the Department of Health, would rely on a combination of employer-based insurance and expanded public programs to provide all of the State's 2.5 million uninsured residents with basic insurance protection or, alternately, just children under 18. The most distinctive provision of the plan (known as UNY\*Care) is one that would establish the State as the sole buyer and payer of hospital, physician, and other acute health care services, both under private insurance as well as the Medicare and Medicaid programs. In addition, UNY\*Care would negotiate and prospectively set the rates providers could charge for their services. Some version of this proposal will be introduced in

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the legislature in 1990 and is expected to be met with resistance from business groups and providers.

A plan of similar philosophy is under discussion in Washington. The proposed Universal Health Access Act of 1990 would authorize the recently created Health Care Access and Cost Control Council to develop a uniform benefits package as well as uniform prospective payment systems. Covered benefits would be comprehensive, including nursing home and community-based services. As in New York, the plan, if adopted, would eliminate the role of private companies in the health insurance business.

## **Cost-Sharing Requirements**

Requiring patients to pay when they receive services is a traditional strategy for controlling utilization and spreading financial risk, in both public and private health insurance programs. Cost-sharing has been a State option under Medicaid since the inception of the program. While the number of State Medicaid agencies experimenting with cost sharing declined in recent years (from 35 in 1985 down to 25 in 1990), interest in imposing cost-sharing requirements in other program areas appears to be growing. For instance, in early 1989 New York instituted a copayment requirement on physician office visits under its employee health benefits program. Similarly, Montana passed a law requiring the State workers compensation insurance fund to allow employees the option of including a medical deductible term in any workers compensation policy.

The experience with cost-sharing under Medicaid merits closer scrutiny. States are permitted to require certain recipients to share some of the costs of Medicaid by imposing enrollment fees, premiums, deductibles, coinsurance,

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copayments, or similar cost-sharing charges. Federal regulations specify the standards and conditions under which States may impose cost-sharing and set forth minimum and maximum amounts. Regulations prohibit imposing more than one type of charge on any service or imposing cost-sharing on services to children. In addition, certain services, including pregnancy-related services, family-planning services, and emergency services are exempted from cost-sharing requirements.

In theory, cost-sharing under Medicaid is expected to contain expenditures in two ways: (1) By shifting service costs to recipients, thus lowering provider reimbursement payments by Medicaid and (2) by lowering utilization as a result of heightened recipient awareness of health care costs. In 1990, 25 States imposed cost-sharing, primarily in the form of copayments, on Medicaid clients for at least one service. Existing State copayments requirements most frequently apply to prescription drugs (20 States). Among mandated benefits, copayments were in effect as follows: for inpatient hospital care (nine States), for outpatient hospital care (nine States), for physician visits (six States), for home health care (two States), and for nursing home care (one State).<sup>87</sup>

In an attempt to evaluate the impact of cost-sharing requirements on public sector health programs, HCFA sponsored a study on cost-sharing in Medicaid. The study consisted of a review of the cost-sharing experience in the 35 States that have tried it and case studies in 9 of these States, 3 of which focused specifically on the use of copayments. Despite certain measurement difficulties, the study did conclude that most of the savings from these programs was the result of decreases in provider reimbursements,

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<sup>87</sup>*Analysis of State Medicaid Program Characteristics, 1986*, U.S. Health Care Financing Administration, August 1987.



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not reduced utilization. Annual savings per recipient were highest in Kansas at \$15.81 and lowest in Maine at \$2.46. Prescription drug services consistently produced the greatest savings from cost-sharing, no doubt stemming from the high utilization rates for the service.<sup>88</sup>

With regard to long-term savings, however, the HCFA study yielded less conclusive findings. States reported that startup administrative costs were high. Moreover, the study concluded, "The question still remains as to the full and long-term effects of cost-sharing. There is preliminary evidence that cost-sharing may save more in the short run than it saves over the long run. If cost-sharing reduces preventive service use in a manner that causes subsequent use of high-cost services . . . it may not produce savings in the long run." <sup>89</sup>

Cost-sharing is also the policy of a growing number of State and area agencies on aging. These agencies charge elderly clients fees for in-home services funded by private and government sources. Typically, these services have a relatively high cost per client, such as adult day care and homemaker services. To preserve their commitment to serving low-income elderly clients, area agencies on aging have built such protections as sliding fee scales into their cost-sharing programs. In fact, because their incomes are below the minimum at which charges are levied, most clients still receive the cost-shared services for free. In a recent investigation of these practices, the U.S. General Accounting Office found no evidence to support concerns that cost-sharing would result in shifting services toward higher income elderly individuals.<sup>90</sup>

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<sup>88</sup>Holahan, Bell, and Adler, op. cit.

<sup>89</sup>Ibid., p. VII-36.

<sup>90</sup>"In-Home Services for the Elderly: Cost-Sharing Expands Range of Services Provided and Population Served," U.S. General Accounting Office, October 1989.

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# **The Impact of Medicaid on State Budget Process and Outcome in Connecticut**

John R. Fadoir  
Public Management Consultant



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## Introduction

Lessons about the relationship between entitlement programs, the state of the economy, and budget process and outcomes are learned early in governmental budgeting. In 1961, when I began a 30-year career with the State of Connecticut's budget operation, all appropriations, other than those of the Department of Welfare, were restricted by 8 percent in order to offset a deficiency in the Welfare budget. At that time, we were experiencing a recession. Medicaid had not yet appeared on the scene, but other entitlement programs and the General Assistance program were reacting to the changed economic situation.

Connecticut was in the second year of a biennial budget. The Legislature met on alternate odd-numbered years for a session of approximately 5 months. Since the problem emerged before the scheduled convening and special sessions were virtually unheard of, it was up to the Executive Branch to take action to deal with the anticipated shortfall. The methods employed to reduce expenditure in State agencies, although not very sophisticated and clearly having little regard for program impacts in the agencies subjected to them, are still utilized in many instances some 30 years later. Then, as now, the overriding concern of States was their fiscal health. Unlike the Federal Government, the States are limited by constitutional and/or statutory provisions that make staying in balance paramount.

In an 18-year period as head of the unit responsible for health and human services budgeting, including Medicaid, the instances of entitlement programs dominating budget choices were manifold. Whether it was the opportunity cost of Medicaid growth in setting budget formulation priorities or the frequent outstripping of expenditure estimates in the execution phase, an overall adverse impact was made on other vital programs. Medicaid, more

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than any other program, has become a driving engine in the allocation of resources and the administration of State budgets.

A review of the period from 1986 to 1991, the FY 1992 budget, and speculation on the likely near-term direction of Medicaid will clearly illustrate the impact on government operations of the Medicaid program in Connecticut.

## Connecticut's Medicaid Program

### Program Policy Operations

The following is a partial description of the Medicaid program abstracted from the 1991-92 Governor's Budget.

**Eligibility.** Individuals or families who meet categorical or medically needy criteria are eligible to participate in the program the former through automatic eligibility and the latter by application. Effective January 1, 1989, coverage expanded to include those pregnant women and children to age 1 year with incomes up to 185 percent of poverty. On April 1, 1990, coverage was expanded to children aged 1 to 6 years of age whose income is under 133 percent of poverty. As of that same date, medical assistance is provided for up to 1 year to Aid to Families with Dependent Children (AFDC) recipients who become ineligible for AFDC because of employment.

**Funding.** In order to maximize Federal reimbursement, the program is structured to comply with Federal requirements. Most medical assistance qualifies as Medicaid and is generally reimbursed at a rate of 50 percent by the Federal Government. Expenditures made for Medicaid-eligible inpatient

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and outpatient services in State-operated facilities of the Department of Mental Retardation, Children and Youth Services, and Mental Health are claimed as well. While the original expenditures for these eligible services are recorded in those departments, \$113 million dollars were reimbursed to Connecticut in FY 1990.

**Service.** Connecticut provides all the mandatory services required under Medicaid. The State provides most of the optional services allowed under Title XIX of the Social Security Act. These optional services make available necessary health care that recipients could not otherwise afford and some alternatives that are less expensive than services. Among others, services included are pharmaceutical, intermediate care facilities, psychiatric facilities, dental care, and clinic services. Additional nonmedical services provided in limited amounts with Federal approval to prevent institutionalization include case management, homemaker, and chore assistance services.

**Rate Setting.** Rates are set by the Department of Income Maintenance (DIM), the single State agency for administration of Medicaid, for some 12,000 enrolled providers. Annually established rates for hospitals (out-patient and inpatient), nursing homes, home health agencies, rehabilitation centers, and most independent community clinics are based on reasonable costs associated with providing patient care. Rates for physicians, pharmacists, dentists, vision care, laboratories, radiology, medical supplies, and others are according to fee schedules paying the same fee for the same service to similar providers.

**Fair Hearing.** Aggrieved applicants or recipients may request a departmental hearing. Such hearings number approximately 900 a year.



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**Payment Process.** Providers bill the Department for eligible services, which are processed through the Medicaid Management Information System. Bills are subjected to some 486 automated edits, and payment for complete and proper bills is made within 30 days. The system processes more than 8 million claims a year, provides more than 700 reports on financial and service use, and checks that all sources of private insurance are utilized prior to State payment. A post audit of billings for legal and policy compliance is conducted.

**Cost Control.** Three programs ensure that services are medically appropriate and delivered in the least costly setting. These include prior review and authorization for certain services as to need and delivery setting; retrospective review of services provided, for medical justification, through review of medical records and onsite observation; and services utilization patterns review. Restriction of recipients to selected providers may result.

## **Financial and Budgetary Aspects**

Certain features of the Connecticut Medicaid program are different from those of other States and from the way other programs are viewed within the State.

Connecticut, unlike other States, gross appropriates the entire amount of all Federal and State welfare entitlement programs, even though it is a 50-percent Federal match State. Federal funds received are treated as revenue by the State. Detail accounting data for the Department of Income Maintenance, including those for Medicaid, do not reside on the central accounting system of the State Comptroller. A check is issued quarterly by the Comptroller for each of the appropriated accounts of the Department and deposited by the DIM in its own bank account; detail accounting is done on

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a local accounting system. As previously mentioned, expenditures are made by a variety of other departments for Medicaid clients and claimed by the DIM for reimbursement. All fringe benefit costs for employees of DIM are paid by the State Comptroller and budgeted in that agency. Employees and other administrative costs are not identified with the Medicaid program in budget presentation but are included in a Program Operations and Support category that serves the entire department. The State operates on a modified cash basis. (Expenditures are charged against the appropriation of the year in which they are paid, and revenue is recognized when received except for certain accrued taxes.) Medicaid figures displayed in budget presentations and in common use within the State do not reflect accruals as they would if budgeting was based on Generally Accepted Accounting Principles.

Although major information system development has been accomplished, in recent years relative to the Medicaid program, there is a backlog of necessary upgrades. There is considerable dissatisfaction with information systems and the quality and timeliness of data as well as gap, overlaps, and redundancy of systems and output. Combined with the offset between the State and Federal fiscal years, the complexity of the Medicaid program, and the rapidity of change, maintaining a clear and comprehensive picture of the program is a difficult and challenging task. This holds for the Department and even more so for outside observers and independent analysts.

For the purposes of this paper and consistency with the most public and commonly used Medicaid data available and referred to in the State, the data used will be gross amounts and direct Medicaid appropriations only. For the sake of clarity and understandability, no attempt will be made to reconcile differing interperiod expenditure resulting from State/Federal fiscal year difference or cash/accrual difference.

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## **Connecticut's Budget Process**

In addition to an understanding of the basics of the Medicaid program in Connecticut, some knowledge of the elemental components, sequence, timing, and relationships in the budget process is needed to grasp the consequences of Medicaid growth on the overall budget. What follows is a primer on the State budget process.

### **Budget Calendar**

Under normal conditions, budget policy guidance and instructions are issued in July each year, and budget submissions are due by the first of September. The Governor completes deliberation in late January and presents the budget to the legislature around the first week of February. The legislature meets for 4- or 5-month sessions, with the longer meeting in odd-numbered years. It adjourns early in the months of May or June on alternate years, having enacted the budget before the July 1 start of the fiscal year. Only twice in the past 30 years has the budget not been in place by the fiscal year start.

The State will return to a biennial budget process with budgets submitted in September 1992 for the 1993-95 biennium. The calendar will change accordingly, and existing milestones will be altered or eliminated, and new events, procedures, and processes will emerge.

### **Legislative Handling**

The Legislature is not full-time and special sessions are a rarity. The budget is presented and reviewed as a single unified entity supported by a recommended single appropriations act. Hearings are held by a Joint

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Committee on Appropriations. Additionally, any bill considered by any subject matter committee having financial implications must be referred to Appropriations before it can reach the floor of either house for action. All bills must be accompanied by fiscal notes. Subject matter committees have no legal or formal role in the appropriation process. Substantive legislation may not be included in an appropriation act. Appropriations are generally made for a single fiscal year. Unexpended balances lapse and do not carry forward.

Staffing for the Appropriations Committee is provided by a nonpartisan Office of Fiscal Analysis. The work papers that support the Appropriations Act under consideration or the final are made available as an expression of legislative intent, even though they are not legally part of the Act. Post session, a formal legislative budget document is published by the Office of Fiscal Analysis further detailing intent.

In addition to the professional legislative staff involved in the budget process, majority and minority partisan staff and leadership staff have grown appreciably in recent years. This staff appears to be playing an increasingly larger role in budget deliberations.

## **Intergovernmental Cycle Problems**

It should be noted that, in addition to the difference in fiscal years between the State and Federal Governments, the appropriation cycle at the Federal level, even if deadlines were met, does not coincide well with the timing of State budget decision-making. The State must act without knowing what the President will propose and before Congress has acted. Considering the time between enactment at the Federal level and finalization of implementing

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policy setting and regulations, budget planning and financial management by States suffers and imbalance results.

## **Budget Execution**

In the period between enactment and the start of the new fiscal year, agencies develop an annual financial plan following guidelines and instructions issued by the Governor, the Office of Policy and Management (OPM), and its Budget and Financial Management Division (BFM). This results in a quarterly allotment program that incorporates legislative intent, scheduling of expenditures, planning of transfers between appropriations, and anticipation of additional requirements (possible deficiencies). This process establishes a baseline for monitoring plan to actual as well as a means to assess overall financial conditions and forecast ending balance for the State as a whole. Should a deficiency be projected for the State, the Governor is required to take action to eliminate or moderate such occurrence. Any appropriation may be reduced by up to 5 percent, and the sum of any such reductions may not exceed 3 percent of the total of any fund. Reductions beyond these thresholds require legislative involvement of an interim Finance Advisory Committee (FAC) with joint legislative/executive membership or the full legislature.

Progress is tracked monthly, and a formal report is made by OPM to the State Comptroller and in turn by the Comptroller to the Governor summarizing the fiscal condition of the State to date and for the balance of the fiscal year. These reports include expenditures to date, additional anticipated appropriations required, anticipated lapsing appropriations, together with realized and anticipated revenues and variances from both expenditure and revenue plans. In the course of the year, available balances are transferred to meet additional requirements before a deficiency



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appropriation is sought from the legislature. There is no contingency reserve from which to draw during the year to meet additional requirements. In fact, total appropriations in any year will exceed anticipated revenue (estimated in the Appropriation Act) by an amount equal to a projected total State lapse amount. If a balance were available in the "Rainy Day Fund," it could not be drawn from until after the close of the fiscal year and an actual deficit is experienced.

Unfortunately, although procedures and mechanisms are in place for overall financial management, they are rudimentary and hampered by the information system deficiencies previously noted and their manual nature.

## **Budget Formulation**

Connecticut uses a modified program budget that incorporates program objectives, descriptions, measures, and financial detail down to a "line item" level. The means of calculation, data entry, and submission are performed either manually preprinted forms or by keying an electronic spreadsheet replication of those forms and printing a hard copy. On the whole, the process of budget formulation is very cumbersome, manual, and in need of modernization. An effort is under way to upgrade underlying concepts and methodology and substantially automate both formulation and execution and improve and link necessary management information systems with the budget process. This effort has been, and continues to be, hampered by chronic underfunding related to the protracted financial deterioration of the State and resistance to change on the part of key decisionmakers.

The budget submissions are segmented by Current Service and Options components. Options are further divided by categories of New or Expanded, Reallocation, Reduction, or Revenue. Guidelines provide criteria for



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determining the appropriate category that should be used for each budget request or portion thereof. Essentially, Current Service continues existing policy allowing for inflation at stipulated rates, annualization of partial year costs, collective bargaining and other contractual obligations, case load growth, calculated rate adjustments, and other normal escalators in the cost of doing business.

Options consider changes to the base by proposing policy changes that either enrich existing programs or establish new ones (New or Expanded), swap existing resources for new or expanded programs (Reallocation), cut back on existing operations (Reduction), or present revenue enhancement by means other than taxation (Revenue).

The base budget, or Current Services, is in large part mandated by statute and regulations that are approved by a formal, rigorous, and legally imposed requirement of due process. Therefore, change is not easily or arbitrarily made. Estimates indicate that up to 80 percent of Current Services are deemed to be "uncontrollable," i.e., not reducible without the expenditure of major administrative or political effort or where consensus for change is unachievable. This should be kept in mind as we turn to an examination of the overall State financial and programmatic circumstances from 1986-91, the FY 1992 budget, and beyond. Particular emphasis will be placed on Medicaid's pervasive impact.

## **The Base Year—1986**

Following the recession in the early eighties, the State experienced an unprecedented growth in revenue and a multiyear binge of double-digit expenditure growth. In the 4-year period of FY 1984-87, the cumulative

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amount of State surpluses equaled \$1.361 billion. In addition, a variety of special trust funds were established to siphon off amounts that would otherwise have been added to surplus. A so-called "Rainy Day" fund of up to 5 percent of the General Fund total was created and subsequently increased to 6 percent; taxes were reduced by more than \$500 million.

The total General and Transportation Fund expenditures for FY 1986 were \$4.459 billion, and the increase over the prior fiscal year was \$453 million for a nominal growth of 11.3 percent. The direct appropriation for Medicaid was approximately \$550 million, which was an increase of 11.3 percent as well over the prior year's expenditures. The General Fund portion of the budget was \$3.977 billion, and Medicaid represented some 13.6 percent of that amount. Expenditures for Medicaid were less than the original appropriation, and close to \$4.6 million was transferred from Medicaid to other accounts to cover additional requirements in those areas.

Medicaid was not a priority, not an overriding concern, and not out of proportion with other growth areas. Educational reform and infrastructure renewal (roads and bridges) were the priority concerns following blue ribbon commission reports recommending major program expansions in each area. Education K-12 expenditures in the base year were \$743 million or a larger share of the State budget than Medicaid (18.69 percent vs. 13.6 percent). Transportation was in the midst of a 10-year infrastructure renewal program, with its own dedicated revenue sources that were scheduled to increase as the expenditure stream grew apace with construction projects. Transportation amounted to \$270 million in FY 1986.

All in all, there was not too much troubling the decisionmakers back then.

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## The Climate and the Winds of Change

Adjustments were needed to cover the decline in Federal funds that had started in 1979 and accelerated during the Reagan Presidency. There were constant threats to the Medicaid budget as the Federal Government tried to control entitlements and domestic discretionary expenditures and shift much fiscal and programmatic responsibility to other levels of government.

There were no new Federal initiatives to meet emerging needs such as the homeless, AIDS, the medically uninsured, substance abuse treatment, and a long list of others. The States were increasing their own expenditures, trying to keep pace while fighting a rear guard action warding off proposed reductions, caps, sanctions, and other efforts by the Feds to achieve what has been described variously as new Federalism, de facto Federalism, devolution, or just plain shifting the shaft.

Because of the tremendous growth in revenue, States were able to advance their own programmatic agendas, absorb Federal cutbacks, accommodate unplanned growth in areas such as corrections, and respond to court-ordered increases in expenditures or the negative impact of other court decisions on States, such as re-interpretation of State exemptions under Fair Labor Standards as in the Garcia decision.

Although on the surface 1986 was a "good" year, it was a turning point. With the tax changes that occurred at the Federal level that year, and the expenditure momentum and the psychology of growth that was prevalent, it was a seminal year. The revenue base that supported the budget and the fiscal health of the State started a decline that had its beginnings in that year.

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We will see what happened in the intervening years, leading us up to the present, that set the stage for the FY 1992 budget and a vastly different set of circumstances, in the next segment.

## Since 1986

Substantial experience with State budget would demonstrate clearly their cyclical nature and the limited means available to States to counter downturns in the economy. The experience in Connecticut has shown changes in fiscal fortunes occurring with regularity on about a 5- to 6-year cycle. The foregoing description of the first portion of the decade of the eighties, juxtaposed with what follows, is a current example of what is regularly happening. The effect on program accomplishment, efficiency, productivity, morale, and confidence in government of this fiscal roller coaster, while poorly documented, is nonetheless devastating. The impact varies by virtue of whether or not a program is an "entitlement" or is "controllable."

## Overall Growth

Conditions have changed markedly since 1986. The overall budget growth that had begun with the recovery continued for several years. The nominal growth in the total General and Transportation Funds expenditures was as follows:

Year	Percent Increase
1987	11.0
1988	14.3
1989	13.7
1990	8.80
1991	3.70
1992	5.69*

\*Based on appropriation.

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These robust increases were not unusual. The national average growth in spending from 1982 to 1988 was more than a 50-percent increase, whereas the increases in the Northeast ranged from a low of 53 percent to a high of 90.9 percent. Connecticut's average growth was 67.6 percent for that period.

Because of the balance accumulated in the years when revenue exceeded expenditures by substantial amounts, inordinate growth continued beyond the point where it was supported by current revenue. The last surplus from operations occurred in 1987 and amounted to \$326 million. By 1988, realized revenue was less than expenditures to the tune of \$104.8 million and the draw down of the Budget Reserve Fund (Rainy Day Fund) had begun. Expenditures have exceeded revenues in every year since. With the Budget Reserve exhausted, a deficit of \$157-plus million was incurred in FY 1990 and was added to a deficit in FY 1991 of \$817-plus million to produce a deficit at the close of this past year of \$965.7 million.

In part, it took several years to reduce the rate of overall growth because the General Fund had to increase to absorb expenditures that had been carried by various special funds established with earlier surpluses. A wide array of fiscal gimmicks, such as taking items off budget, changing timing of expenditures and revenue collections, across-the-board reductions, changing retirement contribution calculation methodology and earnings assumptions, and countless others were employed to mollify the fiscal crunch as balances were dissipated and expenditure pressure on current revenue continued upward.

From 1989 to 1991, significant reductions in the budgets for those years amounted to \$995.3 million. Despite being such a large proportion of total expenditures, Medicaid contributed only \$44.8 million of the close to \$1 billion in cutbacks during that period. Of this amount, the largest elements

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were \$17.7 million in nursing home rate reductions and \$14.9 million due to Medicare Catastrophic Health Care Coverage enactment, which was subsequently repealed.

Beyond all efforts at cutback, gimmicks, changing definitions, timing, and the rest, revenue adjustments have been needed as well every year since 1986. The 1989 legislature enacted a total revenue package that raised new revenue for FY 1989 and FY 1990 by more than \$1 billion. Permanent tax increases amounted to an increase of 16.5 percent of revenue. Not all of this increase materialized in actual collections. In a special session some 2 months after the start of this fiscal year, taxes were raised again by \$1.2 billion, or 24.7 percent. While the 1989 action increased rates and broadened bases of existing taxes for the most part, the cornerstone of the new increases is an income tax.

### Medicaid Growth

Unlike the overall growth pattern for the State, which began to subside in FY 1990, Medicaid growth began to accelerate. The following depicts the increases year to year for direct appropriations.

Year	Percent Increase
1987	10.7
1988	15.8
1989	17.7
1990	18.2
1991	23.9
1992	16.8*

\*Based on appropriation.



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Whereas Medicaid expenditures in FY 1986 were \$541 million, the FY 1991 level was \$1.196 billion. Comparing the base year with FY 1992 appropriations gives an increase of 158 percent in Medicaid, a 68.8 percent increase in AFDC, an 81 percent increase in K-12 education, and a 75 percent increase for the State as a whole.

The following is a comparison by selected major components of Medicaid appropriation for 1985-86 and the amounts for 1990-91 for those same categories.

**Selected Expenditures (\$000)**

Component	1986 Appropriation	1991 Appropriation
Long-Term Care	369,929	644,329
Hosp. (In-Pat.)	115,696	149,594
Hosp. (Out-Pat.)	37,302	66,381
Pharmacy	39,315	57,917
Home Health	17,028	43,698
Physician	30,045	34,393
All Others	41,177	92,887
<b>Total</b>	<b>650,491</b>	<b>1,089,199</b>

These increases are due primarily to rate and case load growth. Medical cases grew from 102,739 in FY 1986 to an estimated 157,604 in FY 1992. Estimated recipients in total increased from 249,589 for 1990 to 296,538 for 1992 in an August 1991 projection. The average daily rate for a skilled

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nursing facility was \$55.34 in FY 1986 and \$88.13 in 1990; an intermediate care facility similarly went from \$49.81 to \$79.76. Long-term care is by far the largest component of Medicaid in Connecticut.

This growth has been exacerbated by quality and eligibility changes associated with Federal mandates, the economic climate, rising unemployment, the large pool of medically uninsured, and the growing number of residents living below poverty line. A March 1991 re-estimate of the cost of OBRA '90 alone for FY 92 was \$12,116,079. The recession started in New England, well ahead of the rest of the country, and is likely to continue longer. Unemployment continues to rise with expectations of topping out at 8 percent. Not reflected in the rate is a record level of people who have exhausted their benefits. More than 300,000 residents are believed to have no medical insurance. Census Bureau data indicate that in 1990 Connecticut experienced the largest percentage growth of persons under the poverty level.

## **Impact on Budgeting**

The basis for the vast majority of the annual appropriation for Medicaid is continuation of Current Services. The criteria for determining this level have already been explained. Most of the growth in the Medicaid budget occurs within this category and largely results in updating for annualization of partial year costs, rate, and volume increases. In the FY 1991 budget, for example, \$135.1 million of a total \$676.1 million Current Services increase was for Medicaid. This represents about 20 percent of the total of that category. Part of the dynamics of case load and rate increase is the need for supplemental appropriations for Medicaid. Since FY 1986, when \$4.6 million was transferred out of Medicaid, that account has been a net recipient of supplemental appropriations. Since FY 1987, the amounts have been, in

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millions, \$14, \$36.1, \$36, \$47.6, and \$112.1, despite the fact that each year since FY 1988 the legislature has increased the appropriations amount requested by the Governor. As previously stated, there is no reserve for supplementals. The expenditures of other programs and agencies suffer cutbacks in order to help offset deficiencies such as those common in Medicaid. As discussed previously as well, the sum of all appropriations exceeds projected revenue by an amount of projected total State lapsing appropriations. Medicaid is not generally included in lapse amount, and therefore other agencies carry a disproportionate share of lapses, further reducing their available resources.

Not only are budget choices on initial allocation impacted by the large proportion of current services consumed by Medicaid growth, but also that growth continues during the execution phase to the detriment of others.

Very little of the increase in Medicaid is categorized as being for New or Expanded programs. Of \$815.5 million for this category in a 6-year period, only \$5.6 million was for Medicaid. The State is not choosing to expand or enrich the program.

The following description of what happened with Medicaid and K-12 education in the 1991-92 budget process is enlightening.

The Governor's budget reduced the agencies' Medicaid requests by \$137.5 million by adopting a variety of reduction options. As the year progressed, however, FY 1991 expenditures increased to the point that the legislature added \$158 million to the amount that the Governor had recommended, even though it had adopted most of the recommended cuts. Included in those cuts were:

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Nursing Home Payment Reforms	\$80.0 million
Patient Income Decrease	2.8 million
Rate Freeze & Limit	15.0 million
Eliminate Over-the-Counter Drugs	0.67 million
Eliminate Naturopaths, Podiatrists, and Chiropractors	0.87 million

At the same time, \$13.3 million for 1989 OBRA and \$14.7 million for 1990 OBRA were included in the final appropriation.

At the start of the budget process in the fall of 1990, \$1.372 billion was the amount needed to continue Current Services for Medicaid in FY 1992. The final appropriation, with all the intervening pluses and minuses, was \$1.397 billion or slightly higher. The bottom line was not reduced despite the effort.

The Department of Education Budget, a priority area, did not do as well. Even after the legislature restored some of the cuts that had been included in the Governor's budget, it received \$69.8 million less than what was determined to be necessary to continue Current Services—a 4.93-percent decrease.

The increases for education and Medicaid looked like this:

	91 Actual (\$)	92 Appro. (\$)	Difference (\$)
Education	1.300 billion	1.345 billion	45 million
Medicaid	1.196 billion	1.397 billion	201 million

Medicaid now exceeds the entire budget for the Department of Education, which includes all the aid to local governments for educational purposes.

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Another casualty of need to cut back was the suspension of the provision, enacted in 1988, that indexed AFDC payment to the CPI. This reduced AFDC by 5 percent (~\$24 million) below what it would have been if Current Services had been continued.

There is a petition drive to repeal the new income tax in a special session of the legislature; 3,757 layoff notices, out of a work force of 42,881 General and Transportation funded employees, have been issued. Close to 12,000 others will be furloughed for up to 32 days during the balance of this fiscal year.

Medicaid continues to grow.

## **Speculating on the Future**

Without a basic change, Medicaid will become even more controlling of State budgets. Estimates for Connecticut are that the number of recipients in 1993 will be 323,224, an increase of 18.8 percent over 1991. There already is a tremendous reservoir of medically uninsured in the State. Data from 32 of the general hospitals in the State show a total of \$312 million in unreimbursed costs in a recent 12-month period. Insurers and private pay patients are paying 21 cents of every dollar to cover uninsured costs. Roughly a third of all emergency room and clinic visits in a large urban hospital are by people without insurance.

The State has a 3-year freeze on new nursing home bed construction, and certificates of need are issued on a time-limited basis. Most of the cutbacks and slowing of growth thus far in Connecticut Medicaid have been at the expense of providers. This increases the likelihood of successful suits on the adequacy of rates being brought, as has been the case elsewhere.



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Federally imposed mandates, increasing eligibles and costs, continue to be pursued by Congress. On one hand, advocates for such expansion may see the pressure put on States and cause them to become vocal supporters of some form of expanded national health care system. The Administration has backed expansion of Medicaid as a solution to the medically uninsured problem and as a means of countering the drive for a broader reform of the health care system. Regardless of the motives, the results, for the States, are rapidly increasing costs.

The Connecticut economy, experiencing severe structural problems, is a double-edged sword when it comes to Medicaid. While economic circumstances are increasing eligibility, revenue is declining. The economy is in the 30th month of decline, and some predict at least another 10 months will pass before the bottom is reached. Experts caution that severe economic problems will persist for the entire decade. Unemployment is rising and expected to reach 8 percent. More than 100,000 jobs have been lost, and because of the type of jobs and the circumstances of the sectors of the economy suffering these losses, the likelihood of regaining those jobs with recovery is not great. The downturn is also having a negative impact on health care coverage for those still employed. Coverage is declining while cost to both the employee and employer is increasing. The implication is for greater cost to government programs down the line. If certain coverage is dropped, the potential for seeking government-supported program service is increased. If such a program or individual is not funded by Medicaid, the dollar impact on the State is even greater.

The fiscal condition and prospects for the State are grim. This is the fourth consecutive year of fiscal stress and cutback. The possibility of concluding this fiscal year with another deficiency, even with, and partly because of, the massive tax increase, is real. Agencies have been instructed to identify, on a



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priority basis, another 20 percent of program reductions. Those reductions that are implemented will most likely be part of a permanent downsizing and not simply a matter of deferring expenditures. Those reductions will, in no small measure, be needed to compensate for certain growth in Medicaid. The amount of interprogram competition and resentment that will be created will be significant and detrimental to the entire budget process.

The longer term prospects for growth in Medicaid spending will be greatly influenced by demographics. Data for the past decade indicate a more than 20-percent increase in the population of the State inhabitants who are 65 years of age and older and a corresponding increase in its percentage of total State population. By the year 2010, it is projected that 14.9 percent, or some 522,560 individuals, will be 65 and older. Between 1980 and 2010, the median age of the State population would increase from 32 to 41.5. These data do not reflect the possibility of increased immigration caused by persistent economic downturn and the proportional impact of such a loss.

Computing dollar estimates for Medicaid, or any other program, for future time periods is an activity fraught with hazards. There are a myriad of factors that have to be considered that describe conditions in general and elements exclusive to the particular program. There are few examples of notable success, and rarely is a retrospective analysis done of forecasts of extended periods. One also has to be extremely sensitive to ideological bias of the forecaster. With this caution, however, it is possible to derive some conservative order of magnitude estimates from Medicaid's past history.

From 1967, the first year of Medicaid expenditure in Connecticut, through estimated expenditure for FY 1992, the bottom line has doubled five times with \$359 million to spare. Surveys indicate that State spending for

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Medicaid nationally will double between 1990 and 1995. Total Medicaid spending is predicted to more than double in this period.

Projecting on the basis of the experience of the past 25 years in Connecticut, on a gross and conservative basis, produces some alarming figures. By the year 2000, gross expenditures for Medicaid in Connecticut will be 140 percent higher than FY 1992 projections, or some \$3.352 billion dollars. At the same time, total General Fund expenditures would grow by 47.75 percent to approximately \$10.3 billion. This State total is most likely on the high side, since legislation was passed in the last legislative session to limit total expenditure growth on the basis of a formula that includes growth in personal income. Although calculations on this basis through the year 2000 are not available, the nominal growth forecast is in line with averages of recent Connecticut and all States percentage increases. The Medicaid share of total General Fund expenditures in the year 2000 would be 32.6 percent, calculated on the unique budget presentation basis used in Connecticut.

As frightening as these projections are, it is difficult to imagine that Medicaid, as we know it, will still exist by then. Playing out past experience to the year 2030 puts gross Medicaid costs for Connecticut at \$21 billion.

## Conclusions

States have had a lot of experience with trying to control Medicaid expenditures over the past two decades. The tremendous effort expended has not achieved a reduced bottom line. The current rationing approach in Oregon and the Connecticut long-term care insurance waiver are evidence of a continuing good faith effort on the part of the States to deal responsibly

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with the problems associated with Medicaid. In my estimation, however, they deal with symptoms and not root causes.

What has accommodated the huge increases in Medicaid in the past is substantial revenue growth and the belief that any budgetary and program dislocation suffered by others was a temporary setback at worst and would be made up for in the certain good times to follow. If we are in for a protracted period of tight budgets, downsizing of government, and taxpayer revolt at the State level, the competition between programs will be such that permanent Medicaid dominance of resources will not be tolerated. The political pressure for change will be immense.

The budget process at the Federal level is a shambles and a disgrace. Any notion of professionalism, neutral competence, or the exercise of public administration for the common good has long since vanished. Along with it, any semblance of leadership, active participation, or financial assistance in dealing with chronic, persistent, or emerging problems by the Federal Government has disappeared. The rhetoric accompanying the Federal withdrawal from the domestic field of battle was focused on giving the States the freedom and resources to deal with the problems. The subsequent growth in the Federal deficit has made Federal budgeting a super contentious process, created decision gridlock, and produced more problems and fewer resources for States. Conditions are now such that a similar fate may befall State budgeting. Rationality in budgeting has become an endangered species, as the sins of the Federal Government are visited on the States. Failure to deal with or solve problems at the Federal level has created a financial overburden on States that has been devastating. Without sufficient stability, sacrificing, and reason, a State budget process and outcome can become as ineffectual as that at the Federal level. We will have then reached a point where all levels of government—Federal, State, and local—will be in turmoil.

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Continuing on the shortsighted course upon which we are embarked, where the primary concerns are the immediate political and financial implications, can have serious and unintended results. Unless we engage in a larger sorting-out process, of which a new solution to meeting health needs would be a key part, the impact of Medicaid on State budget process and outcome could be much more severe than previously experienced or imagined.



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# **Expansion in Delaware Health Care Services 1986-91**

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In 1987, the Governor's Commission on Health Care Cost Containment found that "Delaware's health care financing programs for its low-income population (were) relatively restrictive. The State (had) the 33rd lowest income eligibility standard for AFDC and Medicaid, no medically needy component to their Medicaid program, and no general assistance medical care program for poor persons, even those with physical disabilities who (were) unable to qualify for Medicaid." The Commission's report went on to note that approximately 13 to 15 percent (80,000) of all Delawareans were uninsured and that another 35,000 were underinsured and were being primarily subsidized by the private sector through higher than average uncompensated care charges at Delaware's seven private nonprofit hospitals. The Commission's report concluded that the State needed to undertake proactive policies to institute preventive measures to reduce uncompensated care and expand public sector health care coverage and the availability of private health care insurance.

Programmatically, the Commission's recommendations became the blueprint by which the Governor and the General Assembly instituted a comprehensive program to improve the delivery of health care services to all Delawareans. It was recognized that the State could not significantly address these problems without Federal dollars.

The basic approach was as follows:

- Establish a statewide health-oriented public education/awareness campaign, particularly targeted toward pregnant women. In 1986 Delaware had the second highest infant mortality rate in the Nation. The goal was to reduce the incidences of high-risk pregnancies.

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- Expand school-based clinics to reach adolescents who did not have access to primary care physicians.
  - Expand the WIC program to provide supplemental nutritional and educational programs to woman, infants, and children. With additional State funds, the goal was to reduce infant mortality, high-risk pregnancies, low birth weight babies, and the uncompensated care costs of neonatal and long-term care for these children.
  - Expand Medicaid programs for pregnant women whose income was too high for AFDC but below the Federal poverty level. The Commission recognized that, with supplemental Federal funds, the State could reach a broader population.
  - Expand the Medicaid program for low-income aged, blind, and disabled persons whose income was too high to qualify for Supplemental Security Income (SSI) but below the Federal poverty level. (This ultimately became a Medicaid mandate for qualified Medicare beneficiaries.)
  - Enact healthy-lifestyle legislation in order to better educate Delawareans about their responsibility for many of the factors that directly affected their health.

The Commission's recommendations also included:

- establishment of a new Health Resource Management Council funded by the State to collect data, review certificates of need for

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all new medical technologies over \$750,000, and engage in long-term health planning,

- development of cost management strategies for long-term care that focus on least restrictive approaches, and
- expansion of the State's reimbursement rates to nursing home providers predicated on level of care.

In summary, the Commission's recommendations were oriented toward expanding public and private coverage, containing costs, reducing the level of uncompensated care, and achieving the goal of providing primary preventive health care to the State's uninsured.

In order to accomplish these objectives, one of the approaches undertaken by the State was a comprehensive expansion of its Public Assistance programs (including AFDC) in order to reach the populations targeted in the Commission's report. The following chart showing Public Assistance expenditures for the period 1986-91 gives the reader a sense of the programs' overall size.

What this chart does not demonstrate is the true growth in the breadth and cost of the State's new commitments because of the robust economic climate in which these programmatic increases were initiated. Without the programmatic expansions delineated below, the State would have experienced significant decreases in its Public Assistance expenditures and client counts during this 5-year period. In fact, during the latter half of the 1980s, Delaware had the second lowest unemployment rate in the Nation and experienced significant job growth primarily due to the Financial Center Development Act. And it is only now, in the current economic climate, that

**Welfare Expenditures\***  
(dollars in millions)

	1986	1987	1988	1989	1990	1991	% change 1986-91
<b>AFDC</b>							
No. of recipients/mo	22,392	20,962	19,797	19,107	21,318	22,225	-0.8
Expenditure/yr	\$25.0	\$24.5	\$24.2	\$24.7	\$27.5	\$31.4	25.6
State share	\$12.4	\$12.3	\$11.7	\$11.8	\$13.6	\$15.7	26.6
<b>General Assistance</b>							
No. of recipients/mo	2,104	1,619	1,366	1,256	1,317	1,500	28.7
Expenditure/yr	\$2.3	\$1.8	\$1.6	\$1.6	\$1.6	\$1.9	17.4
State share	\$2.3	\$1.8	\$1.6	\$1.6	\$1.6	\$1.9	17.4
<b>SSI</b>							
No. of State-subsidized recipients/mo	414	457	481	492	481	638	54.1
State share	\$0.6	\$0.7	\$0.7	\$0.7	\$0.7	\$0.8	33.3
<b>Foster Care</b>							
No. of children/mo	502	560	580	607	603	594	18.3
Expenditure/yr	\$1.7	\$1.7	\$2.7	\$2.8	\$3.3	\$3.8	123.5
State share	\$1.3	\$1.2	\$2.0	\$2.0	\$2.5	\$2.7	107.7
<b>Day Care</b>							
No. of children/mo	1,335	1,528	2,016	2,130	2,439	3,100	132.2
Expenditure/yr	\$2.4	\$2.8	\$3.9	\$4.2	\$5.2	\$7.1	195.8
State share	\$0.9	\$1.1	\$1.2	\$2.0	\$2.5	\$4.1	355.6
<b>Medicaid</b>							
No. of eligibles/mo	38,008	36,438	35,280	35,039	38,700	42,036	10.6
Expenditure/yr	\$77.3	\$89.9	\$97.3	\$113.3	\$130.5	\$157.4	103.6
State share	\$38.6	\$44.9	\$46.5	\$54.4	\$64.6	\$78.7	103.9
<b>Community Health</b>							
State expenditures	\$9.8	\$11.0	\$12.6	\$15.5	\$16.2	\$16.7	70.4

\*Chart obtained from 1991 Delaware G.O. Bond Prospectus.

the State is recognizing the true cost of the programs implemented between 1986 and 1991.

To comprehend why the State did not experience a decline in Public Assistance expenditures and the resulting implication for future State budgets, the reader must understand the scope of the policy changes enacted over this period. One means of demonstrating how the State undertook these programmatic expansions is to look at the change in eligibility limits for cash assistance as defined in the chart below.

**Changes in AFDC Income, Eligibility Limits, 1986-91 (\$)**

Year	Family Size 2 Monthly		Family Size 3 Monthly		Family Size 5 Monthly	
	Income Limit	Payment Level	Income Limit	Payment Level	Income Limit	Payment Level
1986 (Oct.)	423	229	573	310	832	450
1987 (Oct.)	436	236	590	319	858	464
1988 (Oct.)	456	247	616	333	869	470
1989 (Oct.)	490	265	616	333	869	470
1990 (Oct.)	499	270	625	338	878	475
1991 (Oct.)	499	270	625	338	878	475

A second means of documenting the State’s efforts is a brief review of those programs sponsored by the Delaware General Assembly and implemented by the Department of Health and Social Services during these timeframes.

**Maternal and Child Health**

- added Medicaid coverage for pregnant women and infants with incomes up to 160 percent of poverty, children 1 to 5 years of age covered at 133 percent of poverty and those to age 8 at 100 percent and provided a major fee increase for physicians who care for them;



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- developed "Smart Start" Case Management Program for high-risk pregnant women;
  - extended Medicaid coverage to pregnant teens;
  - extended coverage to severely disabled children;
  - out-stationed Medicaid eligible workers at 14 prenatal clinics;
  - contracted with hospitals, physicians, and nurse midwives in rural areas to provide prenatal care to low-income women;
  - provided 5 years of AFDC increases or rate adjustments; and
  - increased Early Periodic Screening and Diagnostic Training (EPSDT) coverage for adolescents.

## **Long-Term Care**

- established a Medicaid home and community-based care program for technology-dependent children;
- created two new, specialized staff units to administer long-term care;
- developed super-skilled nursing home category expanding coverage to a hard-to-place client base;
- increased eligibility to 210 percent of SSI standard to increase access;

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- initiated a pilot program with two hospitals to expedite LTC applications; and
  - began implementation of Nursing Home Reform in State and privately owned and operated nursing homes.

## **Home- and Community-Based Services**

- initiated home-based care for the aged;
- extended Medicaid-like coverage to the State's adult population supported under the State's General Assistance program;
- developed Medicaid waiver to allow for services to the elderly and the disabled in the community;
- added coverage to rehabilitative services in the community for persons with mental illness;
- added coverage of hospice services;
- developed Medicaid waiver to allow for services for AIDS/HIV patients in the community; and
- covered prescribed pediatric extended-care day programs for previously hospitalized children.

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## Management Initiatives

- implemented a Medicaid Management Information System certified by the Federal Government;
- increased reimbursement rates for maternal and child health service providers, thereby making all rates at least 60 percent of usual and customary level;
- revised Nursing Home Reimbursement Methodology from flat rate to a patient-acuity based system;
- increased third party liability savings 129 percent, from \$5.5 to \$12.6 million;
- included coverage for over-the-counter drugs as an alternative to more costly prescription drugs; and
- implemented Welfare Reform—breaking the chain of welfare dependency by providing education, counseling, and medical benefits to remove clients from the State's Welfare rolls.

The significance of these programmatic changes on the State's budget and Delaware's ability to access Federal funding can initially be seen in the following comparison of Medicaid expenditures from 1986 to 1991, highlighting the true growth in the State's Medicaid program. Over this 5-year period, Medicaid expenditures from all categories increased by 104.6 percent. As the reader will see later, total budget growth was only 55 percent. Medicaid expenditures, therefore, grew at nearly twice the rate of the State's operating budget.

**Medicaid Expenditures\***  
( \$ in millions)<sup>1</sup>

	SFY 1986 Cost (\$)	SFY 1986 % Share	SFY 1991 Cost (\$)	SFY 1991 % Share	% Change 1986-91
Inpat. Hosp	17.5	22.3	44.5	27.7	154.3
Outpat. Hosp	4.8	6.1	9.7	6.0	100.7
Total Hosp	22.3	28.5	54.1	33.8	142.7
Long-Term Care					
Del. State Hosp	2.3	2.9	2.0	1.3	-11.7
ICF-MR	11.3	14.4	22.4	13.9	98.5
Nursing Homes	27.4	34.9	47.7	29.8	74.5
Tot. long-term	40.9	52.2	72.1	45.0	76.3
All other <sup>2</sup>	15.1	19.3	34.1	21.3	125.1
Grand Total	78.4	100.0	160.3	100.0	104.6

\* Data provided by Department of Health and Social Services.

<sup>1</sup>These are total expenditures, not adjusted for third-party collections and year-end lost settlements with hospitals. The \$2.9 million difference between the earlier table and amounts presented here is the total of these adjustments.

<sup>2</sup>Mostly physicians, prescription drugs, and laboratory payments.

To further underscore the degree and importance of these programmatic changes and for the reader to be able to assess their long-term consequences, one need also compare the changes in those eligible for Medicaid over this same time period.

These four tables demonstrate the extent to which Delaware expanded its Medicaid programs to provide increased access to health care services for an identified population. Furthermore, the content of this expansion has been described so that the reader may better understand the program and resource allocation decisions necessitated in order for the State to provide these services. Collectively, the data foreshadow the degree to which future State

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### Medicaid Eligibles\*

Category	SFY1986	SFY1991	% Increase
Aged & Disabled	9,747	11,372	16.7
Adults	9,230	8,700	-5.7
Children	19,249	22,332	16.0
Total Adults/children	28,479	31,032	9.0
Total	38,008	42,404	11.6

\* Data provided by Department of Health & Social Services.

Note: The drop in adults from 1986 to 1991 reflects declining AFDC case load until 1990. During this period, eligibility increases in non-AFDC recipients (such as pregnant women) offset some of the declining AFDC case load, further explaining why there was no reduction in expenditures. With the current recession, full case loads have begun to climb again.

budgets are at risk during periods of economic distress owing to the changing demographics of these targeted populations.

The strategy as implemented was a conscious one to prevent and reduce dependence on State institutions. It was one of addressing major health problems by expanding eligibilities to those who could least afford access to primary health care or the associated costs of long-term care. The strategy was to invest significant dollars in those populations today that would represent tomorrow's costs, if the problems were not addressed, by improving health status in critical service areas.

The size of these new commitments was due to Delaware's traditionally conservative approach to Public Assistance, the fact that its exposure to Federally mandated programs was greater than States with maturer Public Assistance initiatives, and that Delaware had relied more heavily on the

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private sector to provide these health services in the past. Over the last 5 years, the State recognized that the private sector did not have the fiscal capacity to deal with many of these problems and the State had to take a much more proactive position in order to insure that there would be an adequate health care delivery infrastructure in place for the 21st century. Parenthetically, there is an economic competitiveness issue here related to the costs absorbed by the private sector that were recognized but not quantified.

Therefore, observed in isolation, the reader is able to obtain a perspective on Delaware's expansion of health care services in general and its Medicaid program in particular over this 5-year period. And given the State's past tendencies with these programs, it is only through this kind of examination that one can gauge just how far the State has come. But such an analysis would not be complete without comparing the growth in these programs in the context of the priorities and overall growth of the State's budget. To facilitate the reader's understanding, the following charts have been compiled showing the growth in the State's budget and how that compares to the growth in the State's Medicaid budget and the total of all resource allocation decisions made during this time period.

The initial chart shows the growth in the State budget and the budget of the Department of Health and Social Services (H&SS), with and without Medicaid, from 1986 to 1991. The purpose of this chart is to permit the reader to comprehend the significant budgetary growth (55 percent) experienced by the State during the latter half of the 1980s (11.0 percent annually) and the State's commitment to the delivery of health care programs including those not matched by Federal dollars through the Department of Health and Social Services (80.3 percent).



**State and H&SS Budget Growth\***  
(millions of dollars)

	State Budget (\$)	% Change	H&SS Budget With Medicaid (\$)	% Change	% Change Without Medicaid
1986 <sup>1</sup>	927.4	14.4	156.4	7.7	6.8
1987	929.0	0.2	169.1	6.7	5.4
1988	995.9	7.2	186.3	10.2	10.4
1989	1,085.3	9.0	202.9	8.9	5.3
1990	1,169.8	7.8	231.7	14.2	11.2
1991 <sup>2</sup>	1,262.1	7.9	259.7	12.1	7.5

\* Data provided by State Budget Office.

<sup>1</sup>The operating budget for FY 1986 was \$864.5 million, and the remaining \$62.9 million was used for one-time initiatives and debt retirement.

<sup>2</sup>As a supplemental appropriation, \$5.7 million for Medicaid was enacted in support of new initiatives involving indigent health care after adoption of the operating budget.

The second chart shows the dollar and percentage increases in the Medicaid budget from 1986 to 1991 and compares that growth as a percentage of the State budget.

The two charts combined show the level of State resources committed to the Medicaid program and the extent to which they have become a larger part of the State's total appropriation. The final chart puts these increases into perspective by defining the new ongoing resource allocations made between 1986 and 1991 by program. The chart shows that, absent tax cuts and public education, a majority of the new dollars spent have gone into the delivery of health care services within the Department of Health and Social Services.

The policy of tax cuts, one-time allocations in excess of \$100 million (not shown), and controlled spending was a strategy designed to promote rational budget growth. But in reality the increases in services supported by

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### Medicaid Budget Growth 1986-91\*

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Year	Growth in Medicaid as % State Budget <sup>1</sup>	Medicaid Budget (MM)	% Change
1986	4.2	\$38,676.8	10.0
1987	4.5	\$41,907.8	8.4
1988	4.5	\$45,003.0	9.5
1989	4.9	\$50,772.0	10.7
1990	5.5	\$62,542.0	23.2
1991	6.4	\$77,396.8	23.6

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\*Data provided by State Budget Office.

<sup>1</sup>State share of Medicaid only as a percentage of General Fund budget.

Medicaid represented a significant departure for the State from prior budgetary policy. The expanded programs and the dependence on Federal funding enforced significant new restrictions on the State's flexibility to control future resource allocation decisions. A larger share of future appropriation dollars will be required to support the higher Medicaid base. The long-term implications of these decisions will mean that, as revenue growth slows and the client base expands, the State will have to choose between further restricting other programs, raising revenues, or finding more efficient means of delivering health care service.

The State did not make these choices unconsciously. The Governor's Commission on Health Care Cost Containment provided the vision for the State's rapid expansion of Public Assistance and Medicaid initiatives. The Governor and the legislature working in concert brought that vision into focus. And the process of putting all this together was made easy by the

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rapid economic growth experienced by the State over this 5-year period. During this period, State personal income was 105 percent of the national average and in 1989 was 12th highest in the Nation. Because Delaware's revenue base is so dependent on Personal Income tax collection, the State experienced significant revenue growth even in the wake of four tax cuts.

The following chart shows that even with significant income tax reductions, State revenues continued to grow at healthy rates during this period. In addition to high Personal Income tax collections, Delaware saw almost a doubling of its Corporate Franchise tax, a tenfold increase in the Bank Franchise tax and a 50-percent increase in its Corporate Income tax base. The combination of high personal income, a strong job market, more than 70,000 new jobs, and the national economy contributed to the State's strong revenue collections as the following chart shows.

Dealing with budgetary matters in Delaware in this economic climate was fairly uncomplicated. The Governor presents a budget at the end of January to the General Assembly. It is then reviewed only by the Joint Finance Committee, which has equal membership from both Houses of the General Assembly. The committee holds public hearing on all State agency budgets during its winter break and marks up a new fiscal year budget in late spring, after the State's revenue forecasting advisory committee has met in May. With tax cuts being the last programmatic issue addressed in a legislative session, the reader may conclude that State leadership determined that there was the fiscal capacity to pay for the new Public Assistance initiatives adopted.

During the course of these Finance Committee hearings, agencies are asked about unfunded requests submitted to the Governor, and this information was used to make budgetary changes beyond those recommended by the

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**Personal Income Tax/Revenue Growth, 1986-91**  
(dollars in millions)

**Net General Fund Impact of Tax Revenues**

Fiscal Year	Net PIT Revenue (\$)	Revenue (\$)	% Changes	Law Changes (\$) <sup>1,2</sup>
1986*	344.4	889.3	0.8	19.7
1987*	356.4	961.9	8.2	67.3
1988*	378.1	1,027.7	6.8	122.0
1989*	427.1	1,119.3	8.9	144.8
1990	455.8	1,156.6	3.3	180.4
1991	461.0	1,155.2	0.0	214.3

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\*Years in which new tax law changes (reductions) were enacted.

<sup>1</sup>Impact of tax law changes are cumulative.

<sup>2</sup>A majority of the tax law changes are PIT reductions, with all other changes over this period accounting for an estimated \$17.0 million in FY 1991 of the total \$214.3 million.

Note: Data provided by the Delaware Department of Finance.

Governor in his budget. Because of the robust revenue growth characterized above between 1986 and 1991, the same process was followed in each year as the Joint Finance Committee expanded many of the initiatives included in the Governor's budget because of the increased revenue availability. The net effect of those decisions was the programs and resource allocation decisions detailed above.

The development, implementation, and funding of the State's Medicaid program highlighted is straightforward because Delaware's budget process is extremely simple. What is much more complicated is how the State will manage these programs in the future. The Governor's Commission on Health Care Cost Containment was replaced in 1989 by the Governor's Task Force on Indigent Health Care. Its recommendations called for expansions in Medicaid Programs, reforms in health insurance, and universal access to primary health care services for all Delawareans. The General Assembly

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supported those findings and established the Delaware Health Care Commission to implement those recommendations. The Commission was originally budgeted almost \$5.7 million to support Medicaid expansions, initiate pilot programs, and develop new methodologies for delivering health care services in Delaware. These initiatives were initially funded by an increase in the State's Tobacco Tax in FY 1991.

The National Governor's Association is also committed to addressing the problems of the uninsured and underinsured and is calling on the Federal Government to use its resources to help States pay for expanded health care services. Further programmatic changes such as these will leverage additional State dollars and continue this shift in State budgetary resource allocations. With fewer dollars coming in, higher budget bases, and more people eligible for assistance, future budgetary decisions in Delaware will be much more constrained.

One can also project that Medicaid as a proportion of the State budget will continue to grow in the next 5 years at a rate even faster than that of the last 5 years because of these conditions. Total growth in the State's Medicaid budget for FY 92 was in excess of \$17 million (1.3 percent of the total State budget), and for FY 1993 the cost of inflation and increased client load is projected to be well over \$12.0 million without any consideration of programmatic expansion or Federal mandates. Preliminary projections from the State's Budget Office show that by FY 2000 the Medicaid budget could grow by as much as 280 percent (\$267.5 million). These projections are based on current population trends, the escalating cost of health care services, and an expanded population of eligible clients, despite an economic recovery projected in the next several years.

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The State Budget office has also made projections through 2030, and although the numbers seem out of line with potential State revenues and the other budgetary pressures the State will be under, they are reflective of the implications of the State's choice to expand its Medicaid programs, the impact that rising health care costs are going to have on everyone, and the importance of a national strategy to get these problems under control. If the State assumes modest increases in Medicaid payments for State institutions (6 percent through 2000 and 4 percent through 2030) and that Medicaid patients in State institutions decline from 65 percent to 50 percent by 2000 and also if one assumes that the State will take some action to hold down the rate of increase in the cost of health care for this targeted population—i.e., DRGs, rate-setting, managed care alternatives—and assumes a 10-year economic cycle, then Delaware, under current conditions, could anticipate a Medicaid budget of \$1,921 billion in FY 2030. These numbers do not assume significant expansion in current program or a final strategy for dealing with the uninsured/underinsured population. They do reflect a twentyfold increase in Medicaid expenditures.

There is no certainty, if these projections are right through 2000 or 2030, that the State will be able to sustain such levels of spending. In fact, States are already having to reallocate existing resources because of reduced Federal support and increased constituent demands for safer streets, improved infrastructure, access to quality health care, and a public education system that places a premium on education. These demands are made at a time when the resources are not there and when the average citizen has limited faith in government's ability to make strategic spending decisions in the first place. In this environment, it is highly unlikely that tax payers will support increases in taxes to support expanded Medicaid initiatives. And even with an economic turnaround at the State level, it is illogical to expect that these increased costs for expanded Medicaid programs can be met, given the



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already existing pressures without major budgetary changes at the Federal and State levels. Whether there is the capacity to make such changes is yet to be determined.

The one certainty to all of this, therefore, is the findings of each blue ribbon committee. The population requiring the services is identifiable, and if resources are not spent now to address their health care needs, future generations will pay a much greater cost. Delaware can no longer depend on the private sector to provide these services without compensation, meaning that Medicaid expenditures will continue to absorb a larger share of State resources. But if current economic projections are accurate, the State will not be able to afford these programs without some fundamental changes to the existing system.

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# **Indiana: Medicaid Growth Limits State Options**

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Indiana Family and Social Services Administration

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## Summary

The Indiana paper describes an extremely generous Indiana State Medicaid program that until recently has been available only for the few. The multilevel Federal mandates have therefore had a substantial cost increase in two areas: (1) mandated expansions of eligibility; and (2) the mandate protecting spouses from impoverishment.

The most expensive of these mandates in the period 1986-90 has been the 1984 extension of Medicaid coverage to pregnant women and children younger than age 5 in two-parent families who meet AFDC income and resource limits.

However, the substantial cost increases have only just begun. While the cost to Indiana of all mandates is estimated to total \$19 million in 1990, the costs are projected to increase to \$49 million in 1991 and \$70 million in 1992. By 1995, the annual cost is expected to reach \$86 million. The most expensive of these mandates are the extension of coverage to populations of pregnant women and children (\$36 million in 1991, \$58 million in 1995) and spousal impoverishment protections (\$9 million in 1991, \$14 million in 1995).

Because of the limited eligibility in Indiana, until recently the State has not had to devote substantial efforts to control costs. Reimbursement systems are mainly cost based. This system is strongly supported by well-organized provider-advocacy groups. The projected increases have caused a reassessment of this situation. For example, the State is in the process of developing a new nursing home reimbursement system and is considering a DRG-type reimbursement system for hospitals.

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Indiana has a biennial budget that begins July 1 of odd-numbered years. Two factors in the State budget process allow Medicaid at times to avoid immediate confrontation with other budget priorities. First, once eligibility and benefits have been established, Medicaid and AFDC receive "open-ended" appropriations. This means that the Governor and budget director are statutorily authorized to augment the appropriation to provide for underfunding. Second, Medicaid receives supplemental budgets in even-numbered years, especially in response to Federal mandates. For example, a \$33 million supplemental was enacted in 1990, with one of the most significant reasons being new spousal impoverishment costs.

In 1987, the State increased taxes. The individual income tax rate was increased from 3.0 percent to 3.4 percent of adjusted gross income, corporate gross income taxes were adjusted to remove the planned reduction in rates, and corporate supplemental net income taxes were increased from 4.0 percent to 4.5 percent. These increases were linked to increases in education spending and were promoted on that basis.

However, only two-thirds of the net increase of \$600 million in 1988 went to education. The balance has gone to other growing parts of the State budget, primarily Medicaid and corrections. Even the increase has not totally protected Indiana in current years from implementing the lowest salary increases in recent history, having to tightly control hiring, and postponing a number of desired program expansions in other areas.

AFDC increases have been limited by a 1987 legislated 10-percent reduction in the standard of need, a perception that Medicaid increases serve the same population more effectively for the same dollar, relatively ineffectual advocacy, and overall fiscal tightness. There is no explicit tradeoff.

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## Introduction

Indiana is not unlike other States in that it operates on a budget premise that the books must be "in balance" at the end of the State fiscal year. It is also like most other States in that there are ever-increasing demands for public services (which require public funding) yet a distinct distaste for even considering general tax increases.

Indiana is, however, unlike most other States in that Medicaid eligibility is very restricted—Indiana ranked 45th in the Nation in FY 1990 in the percentage of the total population receiving Medicaid (table 1). Once eligibility is established, however, the program is very generous. Per recipient Medicaid spending in Indiana ranked seventh in the Nation in FY 1990, and Indiana provides 28 of the 32 optional Medicaid services—fourth highest in the Nation.

Recent Federal and State mandates are dramatically changing Indiana's Medicaid landscape. What has been described as a "Cadillac" program for the few has been turning into a "Cadillac" program for an ever-expanding population base fostered by dramatic increases in the eligible population of both pregnant women and children and the elderly. This has led to an increased demand on the State's general fund as State-funded appropriations for the medical assistance portion of Medicaid have increased by more than 166 percent since the commencement of FY 1986 (table 1a).

This paper examines the draw on the general fund, summarizes the process through which Indiana addresses the costs, and offers tentative conclusions as to the opportunity costs to other State programs.



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**Table 1**  
**Indiana National Rankings**  
**FY 1990**

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**Medicaid Recipients as a Percentage of Total State Population**

	% of Population	National Ranking
Total recipients	5.58	45
AFDC children	2.80	44
AFDC adults	1.54	41
Age 65 and over	0.84	42
Disabled	1.03	32

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**Medicaid Spending Per Recipient**

	\$ Per Recipient	National Ranking
Total	3,859	7
Nursing homes	12,190	30
Hospitals	1,390	14
Physicians	359	5
Prescribed drugs	425	1
All other	2,106	31

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Source: HCFA 2082 reports, U.S. Census Bureau.

**Table 1a**  
**Medicaid Budget Requests v. Appropriations**  
**State General Funds**

Fiscal Year (millions)	Fiscal Year (millions)	% Change
1986 Request \$297	1987 Request \$306	3.03
1986 Appropriation \$297	1987 Appropriation \$306	3.03 (FY 1986-87)
1988 Request \$375	1989 Request \$414	10.4
1988 Appropriation \$372	1989 Appropriation \$411	21.6 (FY 1987-88)
		10.5 (FY 1988-89)
1990 Request \$532	1991 Request \$628	
1990 Appropriation \$543	1991 Appropriation \$706	32.1 (FY 1989-90)
		30.0 (FY 1990-91)
1992 Request \$704	1993 Request \$791	
1992 Appropriation \$704	1993 Appropriation \$791	-0.29 (FY 1991-92)
		12.35 (FY 1992-93)

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## Federal Medicaid Mandate

The cost to Indiana of Federal Medicaid mandates has risen from only \$4 million in FY 1986 to \$49 million in FY 1991—7 percent of the Medicaid budget. The annual cost of Medicaid mandates is projected to reach \$86 million in FY 1995 (tables 2 and 3).

Some of these mandates—especially those extending coverage to pregnant women and young children—are consistent with Indiana priorities. Indeed, Indiana has frequently exceeded the Federal mandates in this area, increasing coverage to 100 percent of poverty in 1989 when only 75 percent was required and raising the level to 150 percent in 1991 when only 133 percent was required.

Mandated coverage of pregnant women and children above AFDC income eligibility levels accounts for the largest share of the cost of Medicaid mandates in Indiana—approximately two-thirds of the projected \$70 million cost in FY 1992.

As shown in chart 1 and table 4, the largest recipient growth in Medicaid from 1986 to 1991 has been in the "DEFRA/SOBRA" Category (Non-AFDC Pregnant Women and Children), which has grown by 67 percent during that period. This group accounts for a relatively small share of total Medicaid spending, however (table 4a).

**Table 2**  
**Cost to Indiana of Federal Medicaid Mandates**  
**FY 1986-90 (\$ in Millions)**

<b>Long-Term Care</b>	<b>1986</b>	<b>1987</b>	<b>1988</b>	<b>1989</b>	<b>1990</b>
OBRA '87 nursing home reform	0	0	0	0	0
OBRA '87 pre-admission screening and annual resident review	0	0	0	0	0
Spousal impoverishment <sup>1</sup>	0	0	0	0	0
<b>Pregnant Women and Children</b>					
DEFRA '84 <sup>2</sup>	4	8	12	14	14
MCCA '88 75% of poverty (7/1/88) <sup>3</sup>	0	0	0	0	4
OBRA '89 133% of poverty (4/1/90) <sup>4</sup>	0	0	0	0	1
OBRA '90 Newborns/1 year (1/1/91) Children 6 and older (7/1/91) (100% of poverty)	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
<b>Other</b>					
Transitional medical assistance (AFDC) <sup>5</sup>	0	0	0	0	0
VA pensions (OBRA '90) <sup>6</sup>	0	0	0	0	0
Qualified Medicare beneficiaries (MCCA '88 and OBRA '90)	0	0	0	0	0
<b>TOTAL</b>	<b>4</b>	<b>8</b>	<b>12</b>	<b>14</b>	<b>19</b>

<sup>1</sup>Medicare Catastrophic Coverage Act (MCCA) of 1988, effective 10/1/89.

<sup>2</sup>Coverage extended to pregnant women and children younger than 5 in two-parent families who meet AFDC income and resource limits.

<sup>3</sup>Indiana increased coverage to 50% of poverty on 7/1/88 and 100% of poverty on 7/1/88, thus exceeding the Federal mandates. The dollar amount shown in the table are only the costs of going from 50% to 75% poverty on 7/1/89.

<sup>4</sup>The dollar amounts shown in the table are only the costs of going from 100% of poverty on 4/1/90 to 133% of poverty on that date since Indiana had already chosen to go from 100% of poverty prior to the Federal mandate.

<sup>5</sup>Family Support Act of 1988; effective 4/1/90.

<sup>6</sup>Disregard of VA pension income for single veterans in Medicaid nursing homes; effective 6/91, ends 9/92.

**Table 3**  
**Cost to Indiana of Federal Medicaid Mandates**  
**FY 1991-95 (\$ in Millions)**

<b>Long-Term Care</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>
OBRA '87 nursing home reform	3	4	4	4	5
OBRA '87 pre-admission screening and annual resident review	1	1	1	1	2
Spousal impoverishment <sup>1</sup>	9	10	11	12	14
<b>Pregnant Women and Children</b>					
DEFRA '84 <sup>2</sup>	16	14	15	17	19
MCCA '88 75% of poverty (7/1/88) <sup>3</sup>	9	10	11	12	14
OBRA '89 133% of poverty (4/1/90) <sup>4</sup>	11	13	15	16	18
OBRA '90 Newborns/1 year (1/1/91)	0	3	3	4	4
Children 6 and older (7/1/91) (100% of poverty)	0	6	3	3	3
<b>Other</b>					
Transitional medical assistance (AFDC) <sup>5</sup>	0	2	2	2	2
VA pensions (OBRA '90) <sup>6</sup>	0	6	0	0	0
Qualified Medicare beneficiaries (MCCA '88 and OBRA '90)	0	1	5	5	5
<b>TOTAL</b>	<b>49</b>	<b>70</b>	<b>70</b>	<b>76</b>	<b>86</b>

<sup>1</sup> Medicare Catastrophic Coverage Act (MCCA) of 1988, effective 10/1/89.

<sup>2</sup> Coverage extended to pregnant women and children younger than 5 in two-parent families who meet AFDC income and resource limits.

<sup>3</sup> Indiana increased coverage to 50% of poverty on 7/1/88 and 100% of poverty on 7/1/88, thus exceeding the Federal mandates. The dollar amount shown in the table are only the costs of going from 50% to 75% poverty on 7/1/89.

<sup>4</sup> The dollar amounts shown in the table are only the costs of going from 100% of poverty on 4/1/90 to 133% of poverty on that date since Indiana had already chosen to go from 100% of poverty prior to the Federal mandate.

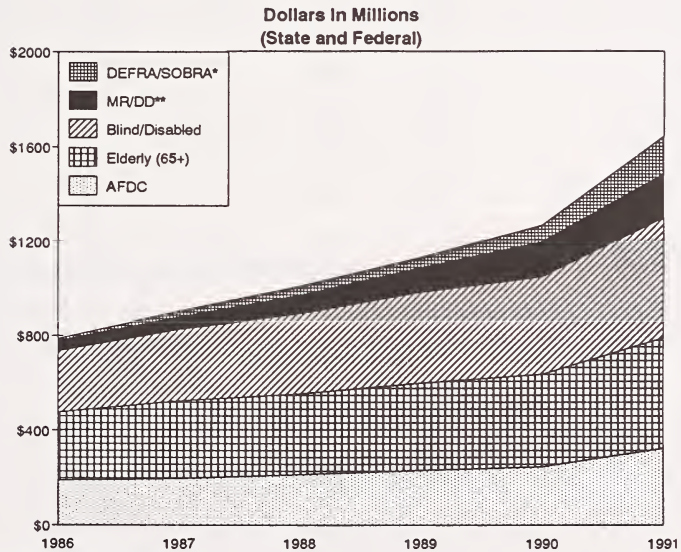
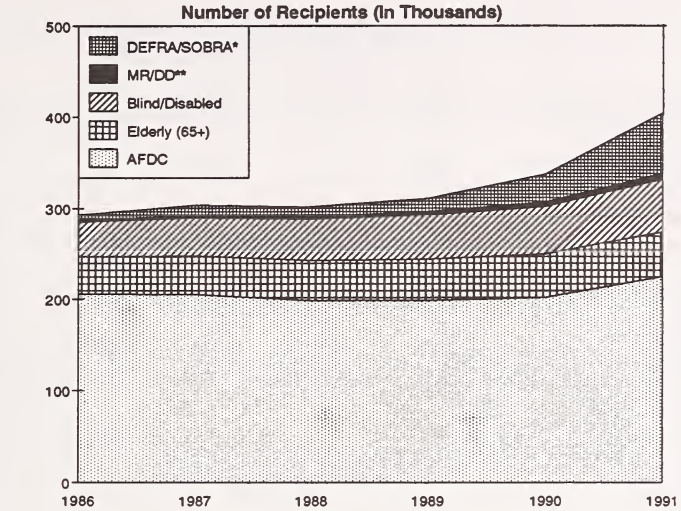
<sup>5</sup> Family Support Act of 1988: effective 4/1/90.

<sup>6</sup> Disregard of VA pension income for single veterans in Medicaid nursing homes; effective 6/91, ends 9/92.



# Indiana Medicaid Trends

## Fiscal Years 1986 - 1991



\*Non-AFDC pregnant women and children  
 \*\*Mentally Retarded/Developmentally Disabled

CHART I



**Table 4**  
**Indiana Medicaid Trends**  
**FY 1986-91**

Recipient Category	Number of Recipients (in thousands)					1991
	1986	1987	1988	1989	1990	
DEFRA/SOBRA*	6	11	11	14	30	66
MR/DD**	2	3	3	4	5	6
Blind/Disabled	38	42	45	49	52	58
Elderly (65+)	41	43	44	45	48	49
AFDC	206	205	199	199	202	225
Total	293	304	303	311	336	404

Recipient Category	Percent Change From Prior Year					Average Increase
	1987	1988	1989	1990	1991	
DEFRA/SOBRA*	75	6	24	110	123	67
MR/DD**	11	23	12	38	12	19
Blind/Disabled	11	7	8	7	11	9
Elderly (65+)	5	3	2	6	4	4
AFDC	(0)	(3)	0	1	12	2
Total	4	0	3	8	20	7

\*Non-AFDC pregnant women and children.

\*\*Mentally retarded/developmentally delayed.

**Table 4a**  
**Indiana Medicaid Trends**  
**FY 1986-91**

Recipient Category	Expenditures (millions of dollars)					
	1986	1987	1988	1989	1990	1991
DEFRA/SOBRA*	10	22	33	40	69	158
MR/DD**	43	56	82	107	153	187
Blind/Disabled	257	300	338	385	412	509
Elderly (65+)	289	329	341	367	388	467
AFDC	189	196	213	232	247	324
Total	788	904	1,007	1,130	1,268	1,645

Recipient Category	Percent Change From Prior Year					Average Increase
	1987	1988	1989	1990	1991	
DEFRA/SOBRA*	117	49	20	74	130	78
MR/DD**	30	47	30	43	23	35
Blind/Disabled	17	13	14	7	24	15
Elderly (65+)	14	4	8	6	20	10
AFDC	4	8	9	6	31	12
Total	15	11	12	12	30	16

\*Non-AFDC pregnant women and children.

\*\*Mentally retarded/developmentally delayed.

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## Cost Containments

Indiana has until recently made few effective efforts to control Medicaid cost growth. As shown in chart 1, Indiana has ranked well above the national average in per recipient spending for at least the last decade, with reimbursement for physicians, hospitals, and prescription drugs ranking unusually high. Per recipient spending on nursing homes is not as high, largely because Indiana has so many light-care patients in its nursing homes. Per capita spending is quite high however—13th in the nation in FY 1990 (charts 2 and 3).

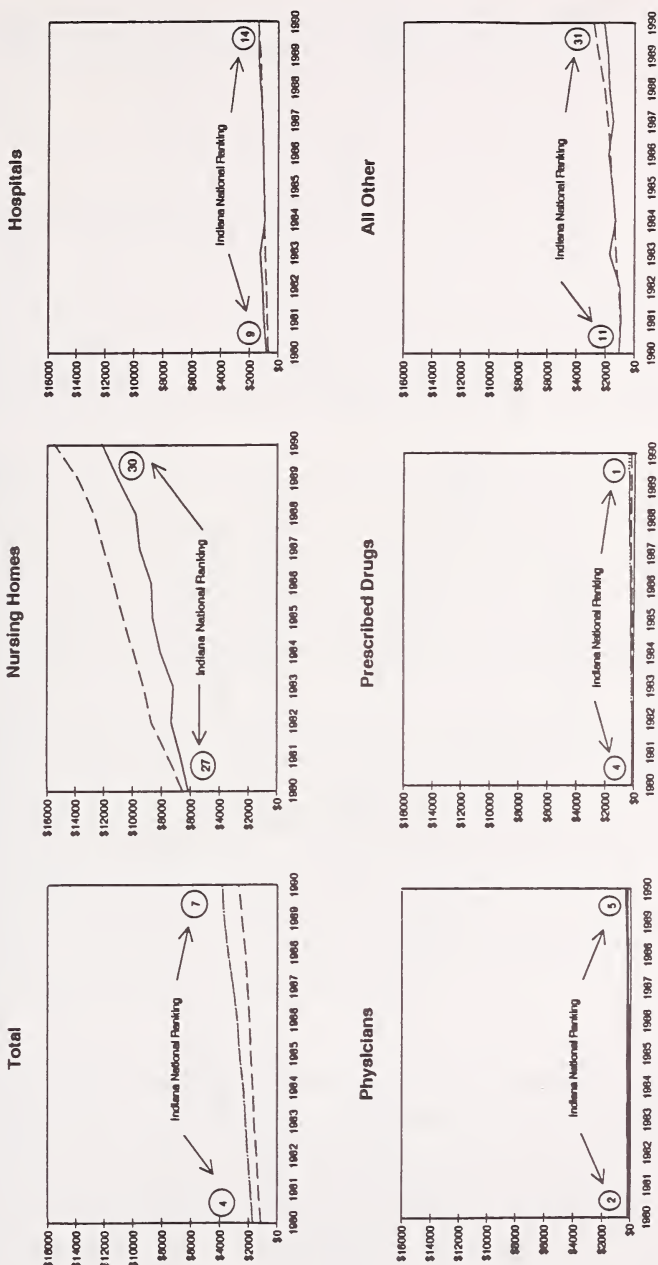
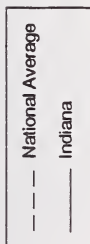
Reimbursement systems for nursing homes, hospitals, and physicians are mainly cost based; so the incentives for cost control and efficient operation are relatively limited.

Indiana has an almost unique system for administering hospital and physician reimbursement (shared only with Texas). The contractor that handles claims processing and payments (EDS) also acts as a partial insurer, bearing part of the risk of loss from higher-than-projected overall costs and sharing in part of the gain from costs that are lower than projected.

The contractor shares in only 15 percent of the gain or loss, however, and only within a relatively narrow corridor; so the incentive effects are relatively limited. Further, the insurer's gains can be maximized by negotiating with the State for high projected overall cost targets as well as by undertaking effective cost-containment measures.

The State is in the process of developing a new nursing home reimbursement system that will be more price based than the current system, with correspondingly greater incentives for efficient operation. The State plans to

# PER RECIPIENT MEDICAID SPENDING INDIANA vs. NATIONAL AVERAGE FEDERAL FISCAL YEARS 1980 - 1990 (STATE AND FEDERAL DOLLARS)



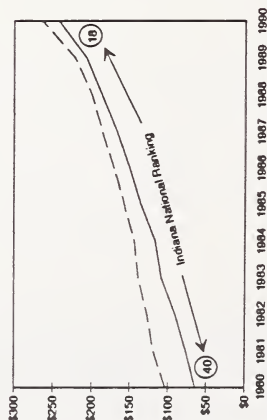
SOURCE: HCFA, ISDPW

CHART 2

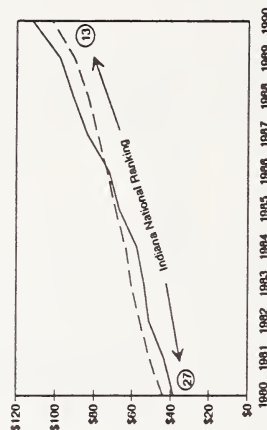
**PER CAPITA MEDICAID SPENDING  
INDIANA VS. NATIONAL AVERAGE  
FISCAL YEARS 1980 - 1990  
(STATE AND FEDERAL DOLLARS)**



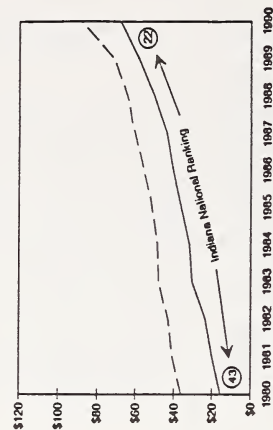
**TOTAL**



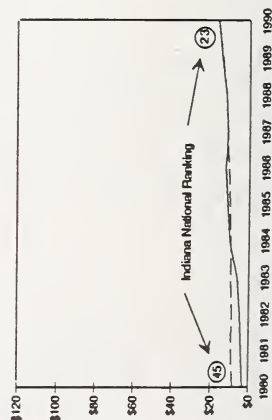
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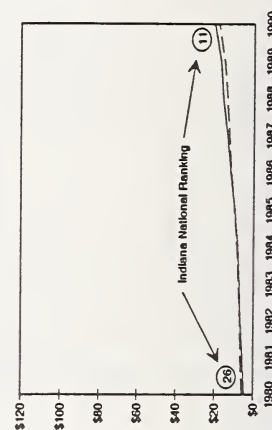
**HOSPITALS**



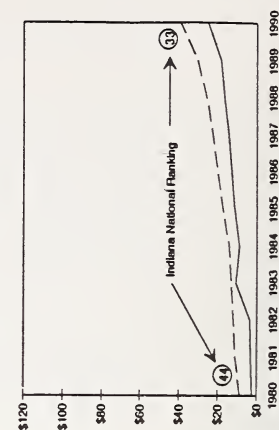
**PHYSICIANS**



**PRESCRIBED DRUGS**



**ALL OTHER**



SOURCE: HCFA, Census Bureau, ISDPW

**CHART 3**

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develop a DRG-type reimbursement for hospitals to replace the current cost-based system. Neither of these efforts has yet shown up in major budget savings, however.

## **Budget Preparation Process**

Indiana's budget is prepared biennially; the budget period commences on July 1 of the odd-numbered years and concludes on June 30 of the odd-numbered years. It is a 2-year budget divided into discrete fiscal years.

The biennial budget process generally is initiated in the summer of the even-numbered years as the State Budget Agency instructs State agencies in the format to be followed in preparing budgets to be submitted in the fall. Deadlines are established and limits are prescribed. The agencies submit departmental budgets by mid-September of the even-numbered years.

The State Budget Agency assures that departmental budgets have been prepared in accord with the instructions and schedules agency hearings before the State Budget Committee. The State Budget Committee is a somewhat unique legislative/administrative organ in that it meets year-round in order to assure that the State's fiscal business can be managed under the structure of a part-time legislature. It is composed of four legislative representatives (one from each caucus) and the State Budget Director.

The hearings before the State Budget Committee afford the committee members the opportunity to ask department directors specific and detailed questions face-to-face. Likewise, it affords the department heads the opportunity to present their perspectives on a variety of departmental issues.



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At the culmination of the hearings (early December of even-numbered years), a consensus is generally achieved and the State Budget Committee submits a recommended budget to the Governor. This document generally provides a starting point for a budget bill to be considered once the General Assembly convenes in January of the odd-numbered years.

Once a budget bill is drafted, it is introduced in the House of Representatives and is heard by the Ways and Means Committee. Once approved in the House, it then travels to the Senate and is assigned to Senate Finance.

If there are substantive changes in the second House, the bill then goes to conference committee, is resubmitted to both chambers for concurrence, and is sent to the Governor for signature into law.

In recent times there have been supplemental budgets enacted in the even-numbered years in order to correct errors or make midcourse budget corrections. Such a correction was made by the General Assembly in 1990 as \$33 million in State funds were added to Indiana's Medicaid appropriation in order to correct potential underfunding caused predominantly by Federal spousal impoverishment provisions contained in the Catastrophic Coverage Act.

## **Legislative Process**

Both the Medicaid and the Aid to Families with Dependent Children programs and appropriations are contained within the Department of Public Welfare's budget request. Additionally, funds may be appropriated in any legislation (generally referred to as outside bills), but any bill with a significant fiscal impact (i.e., greater than \$50,000 annually) must first be

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approved by either the House Ways and Means Committee or Senate Finance, dependent upon the chamber of origin.

Both Medicaid and Aid to Families with Dependent Children are "open-ended" accounts in that the General Assembly has statutorily authorized the Governor and the State Budget Director, in concert, to augment the State general fund appropriation in order to meet any obligations for these programs. This does not remove the responsibility to accurately predict anticipated expenditures for these programs, as inadvertent errors could cost the State tens of millions of dollars it would otherwise spend in a different manner. As an example, the Medicare Catastrophic Act of 1988 did not even exist when the Medicaid budget was drafted during the summer of 1988. When the biennial budget was enacted during the spring of 1989, Medicare Catastrophic was law but was not well understood by Indiana lawmakers and budgeters. Later in 1989, as noted above, it was determined that certain assumptions regarding spousal impoverishment provisions of the Act were incorrect and, in concert with other mandates, necessitated an increase to the State Medicaid appropriations by \$33 million in the supplemental budget of the 1990 General Assembly. Conversely, overestimates limit the ability of the General Assembly to properly fund other State priorities.

Traditionally, different legislative committees deal with issues dealing with Medicaid (Health) and Aid to Families with Dependent Children (Families and Children), but changes in these programs usually have fiscal impacts which exceed the dollar-limit rule mentioned above. Once the fiscal impact limits are exceeded, the proposed legislative changes would be funneled to the respective budget committee in each chamber, where they would be forced to compete for limited funds.

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**Table 5**  
**Indiana AFDC Payment Levels, 1985-90**

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Year	Standard of Needs Schedule <sup>1</sup>	Maximum Legal Payment <sup>1</sup>	Average Payment Per Family	Indiana National Rankings <sup>2</sup>
1985	\$363	\$316	\$223	40
1986	363	316	218	42
1987	385	346	230	42
1988	385	346	263	34
1989	385	346	263	36
1990	385	346	264	36

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<sup>1</sup>Family of four.

<sup>2</sup>Average payment per family.

This effectively reduces the needs determination by 10 percent and creates additional restrictions on the "poorest of the poor." Numerous legislative attempts have been undertaken to repeal the ratable reduction requirements, but with a potential fiscal impact on the State's general fund of an estimated \$31 million annually, it has not been successful to date.

## Taxes

Senate Bill 390 of the Special Session of the 1987 Indiana General Assembly dramatically increased tax revenues through the expansion of income taxes on both corporations and individuals.

The Individual Income Tax was increased from 3.0 percent to 3.4 percent of adjusted gross income. Corporate gross income taxes were adjusted to remove the planned reduction in rates, and Corporate supplemental net income taxes were increased from 4.0 percent to 4.5 percent.

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Although these increases were linked with dramatic funding increases in education, once funds are deposited into the general fund, they become fungible for all demands on that fund. Indeed, total general fund obligations increased by slightly more than \$600 million between the 1987 State fiscal year and the 1988 fiscal year, while the amount of that increase appropriated for education reform was slightly less than \$400 million for the same period.

## **Other Factors**

There is increasing pressure in Indiana to achieve a degree of uniformity between programs that serve the same populations.

Income eligibility standards in Indiana for both the Maternal and Child Health clinics and the Women, Infants, and Children (WIC) are at 185 percent of the Federal poverty standard, while by State mandate, the income standard for Indiana's Medicaid program (pregnant women and infants) is at 150 percent of the same Federal standard. Children up to age 6 are covered at 133 percent of the same Federal standard, while children 6 and older are covered at 100 percent of that standard. This "tiered" system emphasizes the inequities in eligibility, resulting in efforts to resolve those inequities with subsequent fiscal impact.

Should the legislature decide that changing this tiered eligibility system to a more level one is a public policy statement they desire to make, then this also reduces the flexibility to make adjustments to AFDC or any other State program.

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## Conclusions

Indiana, like most of the Nation, is still feeling the impact of lost tax revenues due to the general economic recession. However, unlike numerous other States, Indiana was not forced to increase taxes in order to fund increasing Medicaid mandates, education reform, expanding prison populations, and other necessary services.

The ability of the financial managers in Indiana to predict revenues and to examine all the measures necessary to maintain fiscal integrity is noteworthy. Beyond delaying certain payment streams a few days here and a few days there, there were strict spending limits placed on State agencies. Salary increases are among the lowest in history and hiring in State government is tightly controlled. Program expansions—beyond those which, if not funded, might jeopardize large Federal subsidies—have been postponed, regardless of need and merit.

To characterize Medicaid as the culprit which, through Federal and State expansion mandates, has denied any expansion in AFDC would be unfair. It would be just as "fair" to portray public education funding needs as the culprit. Funding public education in Indiana is at the top of the agendas of the legislature and the Governor.

Correctional issues have also cost Indiana taxpayers hundreds of millions of dollars in construction and operating costs in recent years. Societal pressures to convict and sentence have dramatically expanded the prison populations and precipitated the need for additional correctional facilities and staffs.

Medicaid expansion has truly been a financial burden for the reasons expressed in this report. Medicaid provides tangible results that are readily



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quantifiable, and expansions are also readily quantifiable. Sick, poor people get medical care. On the other hand, the benefits of AFDC expansion are much less quantifiable. Claims that adequate support to poor individuals may actually provide less direct benefits by reducing crime and ultimate incarceration (yet another taxpayer cost) are common but not readily quantified.

In Indiana, if the potential expansion of Medicaid benefits does preclude the potential expansion of assistance payments through AFDC, then it is merely one of many financial pressures on the budget process. More likely, the general perception that the State is providing markedly expanded Medicaid benefits to poor people does more to hinder the serious consideration of expanding yet another government program for a similarly affected population.

## Outlook for the Future

Indiana faces, as do other States, continuing pressures for cost growth in Medicaid: rising health care costs, expanding eligibility for young children above the poverty line, the growing share of elderly in the population, and expanding opportunities for home and community-based care for the mentally retarded, developmentally disabled, and the elderly.

At the same time, Indiana has greater opportunities for cost containment than many other States, since Indiana has been relatively slow to adopt cost-containment initiatives that have been in place for many years in other States. Plans include:



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- Reform of outmoded cost-based reimbursement systems for long-term and acute care;
  - Revisions in medical policy, prior authorization, and utilization review guidelines;
  - Improvements in budgeting, financial management, and contractor monitoring capabilities;
  - Investments in preventive care for pregnant women and young children; and
  - Development of less costly and more appropriate home and community-based alternatives to institutional care for the elderly and disabled.

How these contrasting pressures will net-out in terms of overall Medicaid cost growth is almost impossible to predict at this point. Part of the uncertainty results from the fact that success in cost containment could pave the way for broader Medicaid eligibility, since it is partly the unusually high per recipient cost of Indiana's Medicaid program that stands in the way of eligibility expansion.

The authors have made a concerted effort not to lay sole blame for lack of action on AFDC benefit levels at the doorstep of Medicaid, but rather that blame must be shared by other State priorities competing with Medicaid and AFDC for limited State resources. Medicaid may not break the bank, but in concert with public education and court-ordered changes in the correctional system, it will certainly eliminate State cash reserves and dramatically

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influence the ability of the State to finance existing services with current revenue-generating mechanisms.

The anticipated turnaround of the economy will undoubtedly enhance the State tax revenue picture, but with increasing costs anticipated with Medicaid and public education, it is doubtful that traditional cash reserves will be substantially replenished.

The situation beyond this decade is naturally difficult to predict, but it seems likely that the distinct differences between the types and levels of services from State to State will diminish. Given this and the inclination of Congress, and specific Congressional leaders, to ignore the pleadings of State governments, it may be assumed that eligibility will be expanded. In spite of this, or perhaps because of it, services will be more tightly controlled as the government's "share" of the health care business grows.

The future of Medicaid is inextricably linked with the future of private health care insurance and the increasing emphasis for government intervention through either cost controls or national health insurance. If Medicaid eligibility increases even more dramatically, then it will surely be the precursor for national health insurance; some would already give it that title. This evolution will surely occur if both the public and private sectors fail not only to respond to changing health care economic indicators, but also to plan for them. National health insurance may bring about not only uniformity among geographic areas, but also the troubles that accompany forced uniformity.



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# **Medicaid Cost, Growth, and Impact: The Kentucky Case**

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\*The author expresses special appreciation to Anna Smith and Diane Hancock of the Kentucky Governor's Office for Policy and Management for their assistance in acquiring data and reviewing and commenting on earlier versions of this manuscript.



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## Introduction

The challenge of providing a broad-based system of health care services has "faced the Nation" for several decades. This national challenge has been responded to by a mix of programs and initiatives, including (1) enhanced privatization of health care services, (2) revisions in the role of insurance companies and "third party payers," (3) adjustments to insurance options, (4) evolution of health maintenance organizations (HMOs), (5) new State initiatives to provide insurance or health care cost assistance for the uninsured or underinsured, (6) broadening and deepening of services provided through Medicare, and (7) the rapid growth of the population served and services provided by Medicaid, particularly since 1985, among others. While there have been numerous health care initiatives, and enhanced financial support from the public and private sector, recent estimates indicate that some 35 million Americans<sup>91</sup> remain uninsured or are not covered by other health care programs. Consequently, they remain exposed to severe medical costs and financial risk as a result of having been left behind in the process of changing and adjusting our system of health care support and financing.

This paper focuses on one piece of the medical services puzzle: Medicaid. Medicaid was created in 1965 with the principal purpose of providing health care services for welfare mothers and their children. Shortly thereafter, the program was expanded to complement Medicare benefits for elderly or disabled persons with subsistence level incomes (SSIS). The program has realized considerable growth since that time as a result of new provisions,

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<sup>91</sup>Estimates of numbers of uninsured Americans vary considerably. See, for example, Tony Hutchinson, "The Medicaid Budget Bust," *State Legislatures*, June 1991. The actual number, of course, varies with the status of the economy, employment status (including sector of employment), and changes in Medicaid and other program eligibility.

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new Federal mandates (provisions which must be complied with by the States for them to receive their share of Federal Medicaid dollars), and the gradual implementation of an "implied" Federal policy of using Medicaid as the principal vehicle for providing medical services to the economically disadvantaged.

The fiscal impact of that broad Federal policy direction has been dramatic in terms of Federal and State Medicaid expenditures. Medicaid has expanded to cover some 28 million United States citizens since 1965 (approximately 10 percent of the total U.S. population).<sup>92</sup> Total Medicaid program costs for 1991 have been estimated to be \$90.3 billion, which compares with \$40 billion in 1985. Medicaid enrollment figures grew from approximately 22 million in 1985 to 28 million in 1991. While future growth estimates vary considerably, a recent estimate indicated that Medicaid coverage would be extended to 32 million individuals by 1993, with expenditures increasing to approximately \$130 billion.<sup>93</sup> Other forecasts are even more dramatic as analysts try to account for the simultaneous impacts of a growing recipient base, a broadening and deepening of services provided through Medicaid as a result of new mandates (federally legislated and administratively regulated), State expansion of Medicaid coverage resulting from State implementations of optional Medicaid services, and other initiatives. Medicaid growth has also occurred as a result of welfare reform and the initiation of new State programs to complement other human services programs, such as Kentucky's ratable reduction program. The cumulative affect of Federal mandated program expansions and State program initiatives has been to create a State Medicaid program financing crisis. Such actions have also contributed to an

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<sup>92</sup>*The Wall Street Journal*, "Medicaid Is Beginning to Look More Like Part of the Problem With the Health Care System," Thursday, August 8, 1991, p. A 14.

<sup>93</sup> *Ibid.*, p. A 14.

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overall State fiscal crisis and has placed the future of the Medicaid program in jeopardy as States struggle to meet their Medicaid program match requirements along with other State program needs. The States' fiscal problems may be further exacerbated by Health Care Finance Administration (HCFA) attempts to restrict State options for generating funds to utilize in meeting Federal Medicaid match requirements.

In addition to program coverage growth, Medicaid costs (reflecting general health care cost growth) have been buffeted by double-digit cost increases. While such cost increases are affected by multiple factors, including (1) new technologies, (2) new and improved practices and procedures, and (3) general health sector inflationary pressures which are well above price level changes in other economic sectors, Medicaid service costs have combined with program expansion impacts to make the Medicaid financing issue the major, or one of the major, fiscal policy issues facing the States and, more recently, the Federal Government. Moreover, due to the various initiatives undertaken by the States to meet Federal matching requirements, the Medicaid issue has emerged as the principal intergovernmental fiscal relations policy issue as well.

The purpose of this paper is to review Kentucky Medicaid program cost growth and to consider factors associated with that growth. Consequently, it includes (1) a review of the Kentucky Medicaid program administrative setting, (2) a review of the Kentucky overall and Medicaid budgetary process, (3) an assessment of Kentucky Medicaid cost growth for the period of 1986 to 1991, (4) an assessment of the factors which contributed to the extraordinary growth in Kentucky Medicaid costs, particularly since 1985, and (5) a perspective on the probable Medicaid growth path which Kentucky may experience in the future. The future fiscal impact of continued rapid

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Medicaid growth on the Kentucky budget outlook for other State fiscal and budgetary priorities and needs is also considered.

## **Kentucky Medicaid Program: Administrative and Organizational Setting**

The Kentucky Medicaid program is administered by the Department for Medicaid Services of the Cabinet for Human Resources (CHR). The Cabinet was established in 1973 as part of a major State government reorganization. The Human Resources Cabinet, which was created by placing all human resource and related programs in one cabinet, is the largest of the Kentucky program cabinets in terms of people employed and total resources expended per fiscal year from all sources (general fund, agency fund, and Federal funds). The Department of Medicaid Services was established in 1986. It had previously been a component of the Department of Social Insurance. The two major appropriation units of the Department for Medicaid Services (administration and benefits) constitute approximately half of the Cabinet for Human Resources budget and dominate the other CHR programs in terms of size and scope (other Departments are Social Insurance, Employment Services, Health Services, Mental Health/Mental Retardation, and Social Services). The Cabinet also houses the Commission for Handicapped Children and the Commission for Health Economics Control as well as Cabinet administrative and support services. It should also be noted that the Department for Medicaid Services is as the Medicaid State Agency for Kentucky.

The Cabinet has centralized policy and budget, personnel and management, and other administrative and support staff, although the Department is responsible for estimating and analyzing specific Medicaid cost data and for

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initiating reimbursement rate adjustments and other program content and management initiatives. Among those responsibilities are (1) program development and budget, (2) program services, (3) reimbursement and operations, and (4) patient access and assessment. As such, the Department, as part of the Human Resources Cabinet structure, has significant responsibility for analyzing policy initiatives, estimating Medicaid cost changes, and initiating financial and reimbursement and Medicaid institutional relationship changes. Such changes take place, however, within the overall policy guidance of the Cabinet Secretary and the policy-making processes of the Governor's Office and his policy support staff (the Governor's Office for Policy and Management) as well as the Kentucky General Assembly.

## **Kentucky Budget/Policy Process**

The Kentucky biennial budget and policy development process has undergone periodic changes since the basic Kentucky budgeting and policy analysis system was established in 1973 as part of the previously referenced comprehensive State government reorganization effort. Initially a part of the Kentucky Department of Finance, the Governor's Office of Policy and Management (GOPM) was transferred to the Governor's Office in 1983 and emerged as the principal central policy staff office of the Governor. The Office also serves as the central budget office for the State of Kentucky and carries out the traditional budget office functions of budget policy development, budget preparation, budget execution, and financial policy assessment. The Office also prepares the Executive Budget, which includes the Governor's budget recommendations, and transmits it to the Kentucky General Assembly. The Office also has a lead role in testifying before the various legislative committees regarding the Governor's budget



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recommendations in coordination with the various Governor's Cabinet officials (including, for example, the Cabinet for Human Resources).

GOPM budget analysts work directly with the Cabinet and Department for Medicaid Services staff in the preparation of the Department's budget request. Budget requests are prepared for the two major programs for Medicaid (administration and benefits) and are submitted to the GOPM as components of the overall Cabinet for Human Resources budget request. Such budget requests are reviewed by the GOPM staff and Governor regarding overall costs as well as program mandates, proposed optional service expansions, or other program initiatives as part of the executive budget preparation process. While overall appropriations for the Cabinet and the Department have tended to follow executive branch recommendations, the Kentucky General Assembly has made adjustments and significantly influenced the direction and content of program change over the past two or three budget periods.

Legislative initiatives have included the "ratable reduction" program, which is designed to extend AFDC eligibility for AFDC recipients when they join the labor force in positions without health insurance. As a result of their AFDC extension, Medicaid eligibility is automatically extended. The enactment of a tax assessment<sup>94</sup> on medical service providers was another initiative undertaken by the legislature in cooperation with the executive branch during the 1991 special session. The legislation was designed to provide additional funds to assist the State meet Federal Medicaid program match requirements. Legislative adjustments to executive branch budget recommendations begin in

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<sup>94</sup> Kentucky is one of 34 States that have adopted similar programs. See Department of Health and Human Services, Office of the Inspector General, *Use of Medicaid Provider Tax and Donation Programs Needs to Be Controlled*, Report to Gail Walinsky, July 25, 1991.

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the Appropriation and Revenue Committees of the Kentucky General Assembly. Meanwhile, Medicaid and other Cabinet for Human Resources program changes originate in the House and Senate Health and Welfare Committees. The actions of the four separate House and Senate Committees are ultimately coordinated by legislative action. To facilitate its actions, the House has established subcommittees of the House Appropriations and Revenue Committee to consider budget and financial issues for the six major areas of State government, including human resources. Consequently, initial budget review actions and recommendations regarding Medicaid and other CHR programs begin in the Human Resources Subcommittee of the House Appropriations and Revenue Committee. The fiscal impact of this House Appropriations and Revenue Committee structure is to focus initial budgetary tradeoff decisions on tradeoffs between Medicaid and other human resource programs. Subsequent actions, in turn, by (1) the House Appropriations and Revenue Committee, (2) the House, (3) the Senate Appropriations and Revenue Committee, and (4) the Senate focus on tradeoffs between Medicaid and other general fund-supported appropriation units.

The Kentucky Medicaid program, like counterpart programs in other States, has experienced frequent cost-estimate adjustments necessitating Medicaid budget adjustments after biennial budget appropriation processes were completed. Such adjustments have resulted from new Federal mandates, the lack of alignment of the Kentucky and Federal fiscal years (which has created cost-estimating problems), and program cost growth in excess of initial budget projections and cost expectations.

Such Medicaid cost-driven adjustments have resulted in (1) current year appropriation increases from general fund reserves, (2) current year appropriations from quasi-agency funds (Medicaid tax assessment funds), and other program adjustments and reallocations. Such adjustments involve the

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policy-making and budgeting processes of the executive branch and involve the Governor, the GOPM, the Department of Medicaid Services, the Cabinet, the appropriate legislative committees and the members of the Kentucky General Assembly.

Since the Kentucky fiscal year, which begins on July 1, like other States, is not aligned with the Federal fiscal year, which begins on October 1, and since new, unanticipated Federal funds or agency receipts may become available during the budget execution period (after the General Assembly has approved the budget), the Kentucky Legislature included special language in the 1990 budget or appropriations bill to deal with the problem. This language grants authority to the Secretary of the Finance Cabinet upon recommendation of the State Budget Director to increase appropriations from such fund sources during the fiscal year. Such appropriation increases must be reported to the joint Appropriations and Revenue Committee of the Kentucky General Assembly between biennial sessions. Such reporting constitutes a routine reporting function of the General Assembly's interim committee oversight process.

New initiatives, such as the special Medicaid tax assessment legislation of the 1991 extraordinary session of the Kentucky General Assembly (House Bill 21), are considered in light of overall funding needs and priorities. Consideration is also given to the potential "crowding out" effects of the Medicaid program which could result, for example, if Kentucky's new Federal Medicaid matching capacity generated by its tax assessment initiative is not sustained by Federal regulations or legislation. As such, new policy initiatives are considered in a manner consistent with the overall budget process of the Commonwealth.

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If revenue shortfalls should occur and sufficient funds are not available to meet appropriation levels, the executive branch is empowered to take actions to reduce appropriations on a pro rata basis, use funds appropriated to the Budget Reserve Trust Fund, and take such other action as may be required to balance the budget of the Commonwealth. Such reductions might involve Medicaid and other CHR appropriations as well as appropriations for other State agencies. Actions of this nature have occurred during the period considered in this paper, and programs, including Medicaid, have been reduced for budget-balancing purposes. It is also noted that special appropriation bill language permits the executive branch to transfer funds between appropriation units if fiscal conditions require such action.

## **Kentucky Medicaid Program Growth: In Perspective**

As noted, a number of factors have contributed to the growth of the Medicaid program during the period of FY 1986-91. It is difficult to determine precisely the financial impact of various program changes, mandate changes, or State initiatives because of the simultaneous interaction of such program adjustments. In the tables and discussion which follow, emphasis is placed on indicating changes in overall program appropriations and supplementary appropriations along with supplementary information regarding the reasons for appropriation and expenditure changes when explainable. Percentage-change tables are also used to indicate the relative magnitude of change when appropriate.



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## Medicaid Growth: FY 1986-92

Tables 1 through 5 summarize the growth of the Medicaid program in relation to overall initial enacted appropriations from the General Fund (the fund used for State support of general government operations) and in relation to General Fund expenditure revisions due to budget shortfalls, appropriation level increases, fund transfers and the like. Tables 1 through 6 focus on the benefits portion of the Kentucky Medicaid program. Financial support for the administrative program, which is a separate major program and appropriation unit in the Kentucky budget, is reported separately in table 7.

As shown in table 1, general fund support for Medicaid (as initially appropriated by the General Assembly) grew from \$167 million in FY 1986 to \$302 million in FY 1991 and \$346 million in FY 1992 (a 206-percent increase). Meanwhile, Federal matching funds for those initial appropriated amounts grew from \$374 million in FY 1986 to over \$935 million in FY 1992 (a 250-percent increase for the period). Agency fund (claims and recovery funds) support initially enacted varied from zero to over \$4 million in FY 1986. Appropriation adjustments (adjustments made after the budget was enacted during the regular session of the General Assembly) occurred in every year of the period, with adjustments being made for reorganizations, budget reductions, and transfers as indicated. Such adjustments are not included in the enacted figures shown in table 1 by source of funds.

Table 2 compares the annual General and Federal fund appropriation growth for the Kentucky Medicaid program (in percentage terms). Similar percentage change calculations were not made for agency funds because such funds result from claims and recovery actions and do not result from policy actions. As shown, appropriation adjustments for Medicaid benefits varied from a nominal reduction of 2.7 percent in the amount appropriated in FY

**Table 1**  
**Initial State Fiscal Appropriation Levels for**  
**Medicaid Program Support by Source of Funds**

Fiscal Year	Initial Appropriation			General Fund Appropriation Adjustment	
	General	Federal	Agency	Action	Percent Change
1986	\$167,109,200	\$373,891,600	\$4,135,600	Reorganization	N/A
1987*	\$193,238,600	\$457,386,200	0	Reduced General Fund appropriation -13,200,000	-6.8
1988	\$216,606,500	\$512,707,000	0	Budget reduction 19,600,000	-9.0
1989*	\$210,771,500	\$568,186,100	\$2,500,000	Transferred +3,800,000 from DSI benefits**	+1.8
1990	\$227,432,200	\$627,456,000	\$2,500,000	Special Legislative Acts +17,627,600	+10.4
1991*	\$301,899,900	\$823,363,000	\$3,250,000	Transferred from other CHR Agencies +5,955,000** 8,200,500 transferred from other CHR agencies (Includes welfare reform)	+2.6
1992	\$345,579,100	935,279,300	\$3,250,000		

Source: Kentucky Governor's Office for Policy and Management.

\* Beginning year of a biennium.

\*\* Transfers from DSI benefits in FY 1989 included transfers of surplus AFDC funds. Transfers of other CHR funds for FY 1990 also involved surplus funds. Consequently, benefit reductions did not result from these transactions.



**Table 2**  
**Percentage Change In Appropriations**  
**for Medical Program Support:**  
**By Source of Funds, State Fiscal Year to Fiscal Year**

State Fiscal Year to Fiscal Year Change	State Funds % Change	Federal Funds % Change
FY 86 to FY 87	15.6	22.3
FY 87 to FY 88	12.1	12.1
FY 88 to FY 89	-2.7	10.8
FY 89 to FY 90	7.9	10.4
FY 90 to FY 91	32.7	31.2
FY 91 to FY 92	14.5	13.6

Source: Calculated from data provided by the Kentucky Governor's Office for Policy and Management.

1989 as compared with FY 1988 to a high of a 33-percent increase of State appropriations for Medicaid benefits in FY 1991 as compared with FY 1990. The FY 1989 appropriation decrease resulted from an extremely austere revenue and budget condition experienced by the State of Kentucky for that fiscal year, while the FY 1991 over FY 1990 percentage increase is distorted as a result of a \$68 million (\$18 million State and \$50 million Federal) supplemental appropriation for the Medicaid benefit program enacted during the 1990 session of the Kentucky General Assembly. That supplement was required to cover anticipated additional program costs<sup>95</sup> realized during the execution of the FY 1990 Medicaid budget. As a result of that appropriation

<sup>95</sup> The supplemental appropriation involved a "current year" appropriation of \$18 million from surplus general funds and an appropriation of \$50 million of additional Federal funds during the 1990 regular session of the Kentucky General Assembly.

supplement, the percentage increase (33 percent) of State appropriations from fiscal year to fiscal year is distorted for the period. Percentage change figures for the Federal match of the Kentucky Medicaid benefit program follow a pattern similar to the State increases. Actual percentages may fluctuate due to the lack of alignment of the Federal and State fiscal years, changes in the annual Federal match rate, and other factors.

The contrast between initial enacted appropriation levels for the Medicaid benefits program and the final expenditure levels is indicated by examining table 3 compared with table 1. General fund expenditure levels were reduced below initial appropriations in FY 1987 and FY 1988 owing to overall budget reductions experienced by the State for those fiscal years (\$193

**Table 3**  
**Total Medicaid Expenditures**  
**by State Fiscal Year and Source of Funds\***

Fiscal Year	General Fund	Federal Fund	Agency Fund	Total Expenditures
1986	167,809,200.71	404,048,338.32	4,135,600.00	575,993,139.03
1987	179,633,851.92	426,753,986.41	0	606,387,838.33
1988	198,006,500.00	508,826,226.39	1,552,815.83	708,385,542.22
1989	214,571,500.00	591,679,235.55	7,464,784.17	813,715,519.72
1990	251,014,800.00	689,572,349.58	5,050,000.00	945,637,149.58
1991	310,100,384.79	992,149,941.31	74,497,217.27***	1,376,747,543.37
1992**	345,579,100.00	1,340,077,700.00	153,593,400.00	1,839,250,200.00

Source: Kentucky Governor's Office for Policy and Management.

\* Expenditure figures exclude Medicaid administration. Such expenditures are shown in table 7.

\*\* Projected.

\*\*\* \$71,247,200 increase due to implementation of SB 239 (HICAP I) and HB 2I (HICAP II and additional provider tax).

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million, in FY 1987 down to \$180 million, the ultimate expenditure level, and \$216 million in FY 1988 to \$198 million respectively). All of the other years in the review period indicated appropriation supplements or current year appropriations of State and Federal dollars resulting in increases in Federal and State expenditures. Such changes reflect the impacts of the 1984 Deficit Reduction Act (DEFRA 84), Omnibus Budget Reconciliation Act of 1987 (OBRA 87), and other factors considered later in this report.

Of special note is the \$75 million agency fund expenditure shown for FY 1991 in table 3, which includes a \$71 million agency fund increase attributable to Senate Bill 239 (HICAP I)<sup>96</sup> and House Bill 21 (HICAP II)<sup>97</sup> enacted during the 1990 regular and 1991 special sessions of the Kentucky General Assembly, respectively. It is noted that the same legislation is expected to generate approximately \$150 million of State agency matching funds for the State of Kentucky to match against Federal Medicaid dollars in FY 1992. These tax assessment measures were enacted in order to overcome unanticipated extraordinary growth in the cost of the Kentucky Medicaid program in FY 1991.

As shown in table 4, overall growth in Kentucky Medicaid expenditures increased by 46 percent in FY 1991 over FY 1990 and are expected to grow by 34 percent in FY 1992. Also, as shown, Kentucky had increased its general fund Medicaid match appropriations by 24 percent prior to enacting

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<sup>96</sup> HICAP I (included in Senate Bill 239) was enacted during the 1990 regular session of the Kentucky General Assembly. It provided for a 1-percent tax assessment on the cost of hospital care for all patients (Medicaid and other) for hospitals treating Medicaid patients.

<sup>97</sup> HICAP II (House Bill 21) was enacted during the 1991 Special Session of the Kentucky General Assembly. The legislation provided for an increase of the previously enacted tax assessment of 1 percent (HICAP I) to 5 percent on the cost of hospital care and an additional tax assessment of up to 15 percent of the operating costs for cost-based providers and a tax assessment of up to 15 percent of medical revenues for other health care providers.

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**Table 4**  
**Change in Medicaid Expenditures**  
**by Source of Funds in Percentage Terms**  
**(State Fiscal Year to Fiscal Year)**

Fiscal Year to Fiscal Year Change	General Funds	Federal Funds	Agency Funds	Total Funds
FY 86 to FY 87	7.0	5.6	NA	5.3
FY 87 to FY 88	10.2	19.2	NA	16.8
FY 88 to FY 89	8.4	16.3	380.7	14.9
FY 89 to FY 90	17.0	16.5	-32.4	16.2
FY 90 to FY 91	23.5	43.9	1375.2	45.6
FY 91 to FY 92	11.4	35.1	106.2	33.6

Source: Calculated from data provided by the Kentucky Governor's Office for Policy and Management.

\*Percentage change data exclude Medicaid administration expenditure data.

the HICAP program as a means of meeting mandated and expanded program costs, but such appropriations were inadequate to meet new Federal requirements and matching opportunities by about \$70 million.

Total enacted appropriations (initial appropriations without supplements) for the general fund supported activities, the Cabinet for Human Resources (CHR), and the Medicaid benefits program are shown in table 5. Those numbers are used to calculate the relative growth in the Medicaid program compared with the overall general fund and the budget for the Cabinet as shown in table 6. In that table, it is shown that the Medicaid benefits appropriation unit experienced growth from about 6 percent of the overall general fund appropriation level in FY 1986 and FY 1987 to about 7.4 percent of the total Kentucky general fund appropriation in FY 1992. The



**Table 5**  
**Total Initial General Fund Appropriations for**  
**CHR and Medicaid by State Fiscal Year**

Fiscal Year	Total Initial General Funds Appropriations	Total Initial (CHR) Appropriations	Total Initial Medicaid Benefit Appropriations
1986	2,649,857,600	417,170,300	167,109,200
1987	3,062,320,500	497,102,800	193,238,600
1988	3,343,215,100	542,642,900	216,606,500
1989	3,310,333,200	548,831,300	210,771,500
1990	3,482,704,600	566,360,600	227,432,200
1991	4,286,268,300	727,049,200	301,899,900
1992	4,675,523,500	794,735,700	345,579,100

Source: Kentucky Governor's Office for Policy and Management.

1.4 percentage point growth would represent a \$66 million displacement from alternative programs if one assumes, for comparison purposes, (1) that all that amount would be spent and (2) that Medicaid retained its FY 1986-87 proportionate share of the general fund budget rather than experiencing significant growth. Displacement effects or reallocation effects are also evident within the Cabinet's budget, as Medicaid accounted for 40 percent of the aggregate CHR budget in FY 1986 as compared with 46.4 percent in FY 1992 (a potential "within Cabinet" reallocation of over \$47 million assuming CHR would have received the same overall budget in FY 1992 even if Medicaid had not grown so precipitously). A displacement of that magnitude is probably an overstatement within the Cabinet, as budget data indicate that other Cabinet programs grew at about the same rate or exceeded the growth rate for the overall general fund appropriation levels. Another indication of the exceptional Medicaid growth experienced between the FY 1986 and FY

**Table 6**  
**Medicaid Benefit Appropriations**  
**As a Percentage of Total General Fund and CHR**  
**Appropriations by State Fiscal Year**

Fiscal Year	Medicaid Appropriations As % of General Fund Appropriations	Medicaid Appropriations As % of CHR Appropriations
1986	6.3	40.0
1987	6.0	38.8
1988	6.5	39.8
1989	6.4	38.4
1990	6.5	40.1
1991	7.0	41.5
1992	7.4	46.4

Source: Calculated from data provided by the Kentucky Governor's Office for Policy and Management.

1992 period is that while total general fund expenditures grew at 76 percent for the period, Medicaid general fund expenditures grew at 107 percent and total Medicaid expenditures grew by 219 percent.

The Kentucky Medicaid program administrative cost initial appropriations (enactments) and total funds expended from all sources are shown in table 7. It is noted that in several fiscal years, administrative cost reductions (below appropriation levels) were realized. Such reductions involved a number of adjustments, including those carried out in response to budgetary problems and contingency activities.



**Table 7**  
**Medicaid Administrative Costs by State Fiscal Year:**  
**Amounts Enacted and Expended from All Sources**

State Fiscal Year	Enacted	Total Funds Expended
1986	Unavailable	Unavailable
1987	26,320,800	22,023,016
1988	27,919,500	27,862,665
1989	25,550,500	24,909,709
1990	25,874,000	27,934,188
1991	39,248,000	34,499,238
1992	41,312,400	—

Source: Kentucky Governor's Office for Policy and Management.

## Medicaid Growth: Contributing Factors

The rapid growth of Medicaid costs for Kentucky, like other States, is a result of the interaction of several program growth-inducing factors. Included are (1) new Federal mandates for services and program eligibility, (2) increased costs of medical services, (3) additional recipient eligibility resulting from State enactment of optional Medicaid services, (4) requirements regarding reimbursement rates, (5) welfare reform eligibility period extensions, and (6) other special program initiatives such as Kentucky's ratable reduction program implemented in 1989 to extend Medicaid coverage for AFDC recipients when such recipients join the work force in positions that do not provide health care benefits.

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Table 8 presents a history of Medicaid program mandates and summarizes estimates of additional costs per fiscal year associated with their implementation. For example, the pregnant women and children component of DEFRA grew from \$3 million in FY 1986 to \$46 million in FY 1991. Total new mandate costs grew from \$3 million in FY 1986 to \$213 million in FY 1991. The State share of such costs increased, as indicated, from \$8 million in FY 1986 to \$57.6 million in FY 1991. While these new mandate costs are substantial, they do not account for all the Medicaid cost increases.

Another significant cost-increasing factor is the change in the cost of medical services. Such cost increases have exceeded the consumer price index values each year for the period from 1986 to 1990. The medical care price index change over this period averaged approximately 8.5 percent, while the hospital and related-service index increased by an average of 11.8 percent for the same period.<sup>98</sup> Medicaid costs are directly affected by such increases and significantly overall affect Medicaid cost growth patterns realized by the States.

Medicaid recipient numbers have also increased because of program changes, economic conditions, and changing recipient eligibility standards, such as welfare reform and Kentucky's ratable reduction program previously discussed. From October 1987 to October 1990, the total number of Medicaid eligibles grew from slightly over 330,000 to more than 400,000. Pregnant women and children qualifying under poverty level mandates were responsible for about one-third of the growth in the number of eligible recipients for the period.

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<sup>98</sup> Averages were calculated from Bureau of Economics Analysis, Department of Commerce data.

**Table 8**  
**History of Medicaid Program Mandates**  
**FY 1986 to FY 1991**

Fiscal Year		Fiscal Impact (\$ In millions)	Fiscal Impact (\$ In millions)
		Total	State
1986	DEFRA <sup>a</sup> 84	3.0	0.8
1987	DEFRA 84	5.3	1.5
1988	DEFRA 84	8.3	2.3
	Pregnant Women & Children	<u>7.0</u>	<u>1.9</u>
		15.3	4.2
1989 <sup>b</sup>	DEFRA 84	8.9	2.4
	Medicare Premium Increases	2.6	0.7
	Pregnant Women & Children	30.1	8.1
	Medicare Catastrophic Coverage Act & Repeal	<u>(4.7)</u>	<u>1.3</u>
		36.9	10.0
1990	DEFRA 84	9.3	2.5
	Medicare Catastrophic Coverage Act & Repeal	18.7	5.1
	Pregnant Women & Children	43.7	11.8
	OBRA 87	13.8	3.7
	OSHA	6.9	1.9
	Orthodontics	1.5	0.4
	Durable Medical Equipment	2.5	0.7
	OBRA 89	<u>1.5</u>	<u>0.4</u>
		97.9	26.5

**Table 8 (continued)**  
**History of Medicaid Program Mandates**  
**FY 1986 to FY 1991**

Fiscal Year		Fiscal Impact (\$ In millions)	Fiscal Impact (\$ In millions)
		Total	State
1991	DEFRA 84	9.8	2.7
	Pregnant Women & Children	46.0	12.4
	OBRA <sup>c</sup> 87	22.3	6.0
	OSHA <sup>d</sup>	6.9	1.9
	Minimum Wage	8.0	2.0
	Orthodontics	1.5	0.4
	Durable Medical Equipment	5.0	1.4
	Medicare Catastrophic Coverage Act & Repeal	42.1	11.3
	Welfare Reform	13.8	3.7
	OBRA 89	47.0	13.0
	OBRA 90 (Preliminary)	<u>10.3</u>	<u>2.8</u>
		212.7	57.6

Source: Cabinet for Human Resources Department of Medicaid Services.

<sup>a</sup> Deficit Reduction Act.

<sup>b</sup> 7/1/89 ratable reduction—costs unavailable.

<sup>c</sup> Omnibus Budget Reconciliation Act.

<sup>d</sup> Occupational Safety and Health.

Growth in aggregate Medicaid expenditures appear to be influenced by a number of factors, including economic change and Federal and State policy. For example, changes in the relative economic standing of a State that change Federal/State match ratios can also influence State and Federal cost relationships. However, as shown in table 9, such changes have been relatively minimal for Kentucky since the Medicaid program began in the 1960s. Program changes and Medicaid mandates also appear to have a "learning curve" impact as well. In other words, the full impact of such

**Table 9**  
**Kentucky's Federal Medical Assistance Match Ratio Percentages**  
**(Base Years 1962, 1963, 1964 for AFDC and Medicaid)**

Fiscal Year	Begin	End	Federal %	State %
1961-63	July 1, 1961	June 30, 1963	75.57	24.43
1963-65	July 1, 1963	June 30, 1965	75.27	24.73
1965-67	July 1, 1965	June 30, 1967	76.70	23.30
1967-69	July 1, 1967	June 30, 1969	75.25	24.75
1969-71	July 1, 1969	June 30, 1971	74.30	25.70
1971-73	July 1, 1971	June 30, 1973	73.49	26.51
1973-75	July 1, 1973	June 30, 1975	72.12	27.88
1975-77	July 1, 1975	June 30, 1977	71.37	28.63
Interim Quarter <sup>a</sup>	July 1, 1977	Sept. 30, 1977	71.37	28.63
1977-79	July 1, 1977	Sept. 30, 1979	69.71	30.29
1979-81	Oct. 1, 1979	Sept. 30, 1981	68.07	31.93
1981-83	Oct. 1, 1981	Sept. 30, 1983	67.95	32.05
1983-85	Oct. 1, 1983	Sept. 30, 1985	70.72	29.28
1985-86	Oct. 1, 1985	Sept. 30, 1986	70.23	29.77
1986-87	Oct. 1, 1986	Sept. 30, 1987	70.75	29.25
1987-88	Oct. 1, 1987	Sept. 30, 1988	72.27	27.73
1988-89	Oct. 1, 1988	Sept. 30, 1989	72.89	27.11

<sup>a</sup> Federal FY changed from July 1 to October 1.

**Table 9 (continued)**  
**Kentucky's Federal Medical Assistance Match Ratio Percentages**  
**(Base Years 1962, 1963, 1964 for AFDC and Medicaid)**

Fiscal Year	Begin	End	Federal %	State %
1989-90	Oct. 1, 1989	Sept. 30, 1990	72.95	27.05
1990-91	Oct. 1, 1990	Sept. 30, 1991	72.96	27.04
1991-92	Oct. 1, 1991	Sept. 30, 1992	72.82	27.18
SFY 1990-91	July 1, 1990	June 30, 1991	72.96	27.04
1991-92	July 1, 1991	June 30, 1992	72.86	27.14

Source: Cabinet for Human Resources, Department for Medicaid Services.

changes is probably not felt during the first year of expanded service eligibility, as some eligibles may not learn of their eligibility immediately and may begin to take advantage of Medicaid support in later fiscal years. Such delayed impacts may accelerate the growth of Medicaid expenditures in future years beyond the cost growth estimated when such estimates are predicated upon quick recipient eligibility response to new Medicaid provisions. Also, programs such as the Federal welfare reform and the Kentucky ratable reduction programs may be significantly influenced by economic conditions, as new job takers may experience layoffs as the economy deteriorates or employment stagnates. The overall and interrelated fiscal impacts of the Medicaid program are difficult to predict, as most States have experienced Medicaid growth far beyond their expectations during the FY 1986-91 period.



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## Summary and Future Implications

The Medicaid program was designed to provide medical services to economically disadvantaged portions of the population in need of medical services and to encourage nationwide standards for eligibility and services provided. The latter objectives have been achieved through the establishment of Federal mandates which specify standards that the States must meet in order to receive Federal Medicaid cost-sharing support.

During the period chosen for this Medicaid program review, the States have experienced dramatic growth in Medicaid costs as has the Federal Government. Unfortunately, most of the factors contributing to the cost growth are likely to drive Medicaid cost growth in the future as well. Cost-influencing factors such as the cost of providing medical services, continue to exceed the consumer price index (CPI) as providers respond to the growing demand for higher cost services, new technology becomes available, and other cost growth factors disproportionately affect the health care field. New mandates and new State initiatives and optional services are also likely to increase as the Federal and State governments attempt to improve the medical services provided to the underserved and economically needy.

Unfortunately, such expansions pose severe budgetary problems for State governments. As indicated in this report, Medicaid costs are consuming an increasing share of Kentucky's general fund and Cabinet for Human Resources budgets. As such, they are crowding out other high-priority State programs, including education, economic development, environmental management, human service programs, and other critical State government services. Such crowding-out effects cannot be sustained. The States will have to make hard choices to deal with the dramatic growth of Medicaid in the future.

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Even with an improved economic outlook, the States will continue to be impacted by the Federal Government's reduction of general support for domestic programs. Federal program support reductions will require States to replace such support if State economies are to remain competitive. Such replacement will principally need to occur in areas such as infrastructure and other public investment areas where private sector productivity is significantly impacted by public investment. Such replacement initiatives will further constrain the fiscal capacity of the States to absorb additional Medicaid program costs without relinquishing their commitment to the environment, education human service program support, and other vital State areas of responsibility. Further increases in broad-based taxes as a policy alternative are likewise constrained by tax-base enhancement actions of recent years.

In order to mitigate the crowding-out effect of Medicaid program growth, States like Kentucky are developing new and innovative ways and means to generate their Medicaid matching funds. Such initiatives have drawn the attention of the U.S. Office of Management and Budget and the Health Care Finance Administration, and efforts have been undertaken to redistrict the use of non-general fund revenues for Medicaid matching purposes. If such Federal regulatory and other efforts are sustained, the States will face even greater fiscal problems, and the crowding out of State support for education, AFDC, and other critical State programs may reach intolerable levels. The policy options available to the States to deal with this scenario are limited. Among them are more restrictive eligibility requirements, reduced medical service reimbursement fee structures, and program service reductions. The Medicaid fiscal challenge will undoubtedly continue to be one of the major fiscal and health policy issues of this decade. It is becoming increasingly critical that alternate programmatic approaches be designed that assist the States in either accommodating or reducing this dramatic Medicaid cost

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growth. If such approaches are not found, the Medicaid cost problems will attain crisis proportions and the State's fiscal problems may become unsustainable.

## Kentucky Summary

The Kentucky paper describes a biennial budget State that has experienced explosive growth in Medicaid costs since 1985.

Since 1986, Medicaid has been administered by the Department for Medical Services within the Cabinet for Human Resources (CHR). Prior to that point, it was administered as part of the Department of Social Insurance, also in CHR. Other units within CHR include the Departments of Employment Services, Health Services, Mental Health, Mental Retardation, and Social Services, the Commission for Handicapped Children, and the Commission for Health Economics Control.

While the Kentucky Legislature appropriates all funds (general, agency, and Federal), the Secretary of Finance Cabinet is given the authority to increase Federal-fund or agency-fund appropriations when additional unanticipated funds become available from these sources during the fiscal year. Supplemental general fund matching dollars can be transferred from other CHR appropriations, if available, to meet Federal Medicaid match requirements. Current year appropriations (within fiscal year) have also been used to meet supplementary match requirements.

The executive branch is also given the authority to make pro rata reductions in appropriations if revenue shortfalls should occur. Such a reduction was made in 1987 and again in 1988. A reduction was avoided in 1989 by

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transferring funds from DSI benefits, and transfers have occurred each year since.

In 1990, a provider-specific tax was enacted to help pay for the substantial Medicaid program expansions and increases in costs. This has minimized the extent to which tradeoffs have occurred with other programs and benefits. If proposed HCFA regulations become law, a significant tradeoff can be expected to occur.



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# **The Impact of Rising Medicaid Costs— The Oregon Story: 1985-87 Through 1991-93**

R. Jon Yunker

Former State Budget Officer  
State of Oregon

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# MEDICAID IN OREGON

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## Background

Oregon's experience is probably similar to most States. The cost of Medicaid has continued to increase through the eighties and into the nineties. State General Fund expenses (match requirements) were slightly under \$200 million in 1980 and are now over \$600 million. (See appendix, item 1.) Federal entitlement programs in general have increased significantly, while more flexible block grant monies to States have decreased. If future growth follows recent patterns, Medicaid is projected to increase approximately 20 percent a year over the next 6 years. This rapid growth rate will force increasingly difficult policy decisions on other State programs and within Medicaid itself.

Why such a large increase? There are several significant reasons—again, not uncommon among States:

- Federal mandates that increase the population eligible for services. The most obvious example is the Poverty Level Medical Program which has increased from a monthly average of 1,600 eligible in the 1987-89 biennium to 23,000 projected for 1991-93.
- Federal mandates that increase the medical services that must be provided. Changes such as the mandates for Early Periodic Screening Diagnosis and Treatment, which ignore State Medicaid Plan limits, are one example of Federal action in this arena. Nursing home reform and other Federal regulatory requirements on long-term care are other areas of skyrocketing costs.

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- Increasing medical services that have become standard procedures by the medical provider. Both technology and the impact of malpractice awards are driving up public and private expenditures.
  - Increasing costs for specific medical procedures and services. Medical inflation has consistently exceeded overall economy-wide inflation rates.

Specific examples of Federal mandates can be found in the appendix (appendix, item 2<sup>99</sup>), which lists such items as the Omnibus Reconciliation Act of 1987. This mandated medical coverage of children through age 6 who met ADC income standards. The Omnibus Reconciliation Act of 1990 increased this coverage to all children within a certain age bracket with incomes below 100 percent of the Federal poverty level.

Perhaps Governor Clinton of Arkansas, representing the National Association of Governors, was not far from the mark when he said, "It appears to us that what is really happening is a 'back-door approach' to universal health care, using Medicaid as the vehicle and the State's credit cards as the financing mechanism."

In spite of these mandates and alarming costs increases, many of Oregon's poor (and I suspect the Nation's) still are not receiving medical services through Medicaid or any other medical insurance program. In Oregon, approximately 450,000 Oregonians have no health insurance—18 percent of the State's population. This number is increasing 5 percent annually. In addition, of those with health insurance, 230,000 have coverage that does not

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<sup>99</sup>See paper prepared by Vickie Gates for the Oregon State Legislature, *Federal Aid Patterns in the Department of Human Resources—A Decade of Change, 1980-1990*.

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meet basic health care needs. This trend is expected to worsen with increased use of contracted, part-time, and temporary workers.

To respond to these problems, the Oregon Legislature passed the Oregon Health Plan, which includes a defined Standard Benefit Package. (See appendix, item 3.) This plan should provide medical services for almost all Oregonians. For those on Medicaid, it will require a Federal waiver to level services at the Standard Benefit Package and to increase participation. For those not on Medicaid, the State created the Medical Insurance Pool Board to provide standard health insurance coverage to high-risk individuals who previously have been denied medical insurance. (See appendix, item 4.) The State has also increased the requirements of employers to provide adequate medical coverage. Oregon has, in effect, attempted to put together a plan for universal coverage given the Federal inability to address serious health care issues beyond piecemeal, Medicaid expansions.

The Oregon Plan, as outlined in the attachment, also approaches the issue of what should be provided in a radically different way. The priority for services is driven by an assessment of the impact on health outcomes, not by concepts of optional and mandated eligibles and services. The current program's lack of flexibility forces States to make decisions which are poor social and economic policy. For example, to balance its 1991-93 Medicaid budget, Oregon eliminated adult dental care (optional service) and the medically needy, nonpregnant adult group (optional eligibles). Both decisions are likely to produce more expensive, downstream costs.

The legislature has provided this expansion of medical services to the poor through the existing General Fund. The General Fund can make these payments partly because the Legislature consistently has 3 to 5 percent more revenue to spend than the Governor. For Medicaid in particular, no

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additional taxes, surcharges, or fees have been initiated. At the 1991 legislative session, a proposal to raise \$41 million through hospital assessments, designed to restore optional health services for general assistance and Title XIX clients, was voted down.

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## IMPACT OF MEDICAID INCREASES ON OTHER STATE PROGRAMS

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Figure 1 clearly shows that as Medicaid costs increase faster than the growth in the State's General Fund, other programs will receive proportionately less funding.

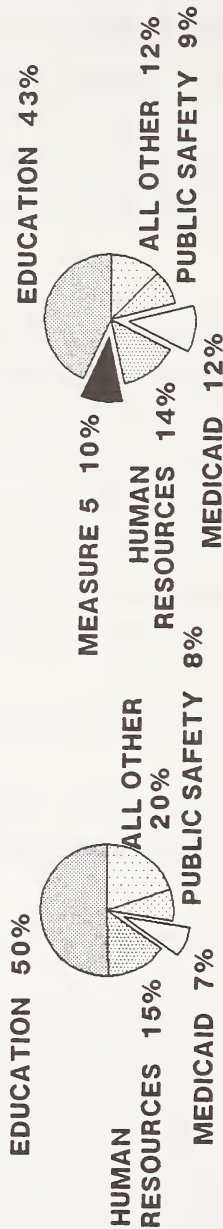
The pie chart also shows the expected impact of Ballot Measure 5. (See appendix, item 5.) Ballot Measure 5 limits property tax rates to \$5/\$1,000 for local schools (phased in over 6 years) and \$10/\$1,000 for all other local governments effective July 1, 1991. Because the voters wanted to protect K-12 education programs while still giving property tax reductions, the constitution now requires the State's General Fund to replace the schools' lost property taxes. This is a State expenditure that will increase from approximately \$560 million in 1991-93 to \$2.9 billion in 1995-97.

Looking at the figures provides the following insights (though no surprises):

- Medicaid costs as a percentage of General Fund will increase from 7 percent in 1985-87 to a projected 19 percent by 1995-97.
- As Medicaid increases, other Human Resource programs decrease.
- Education costs, due to Ballot Measure 5, will increase from 50 percent of General Fund Expenditures in 1985-87 to 64 percent in 1995-97.

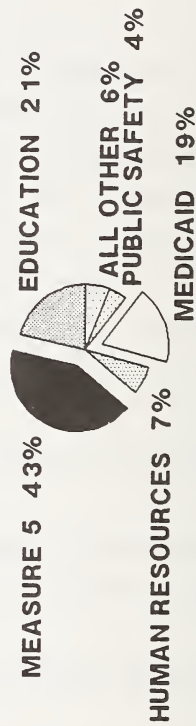


# STATE OF OREGON GENERAL FUND EXPENDITURES BY PROGRAM AREA



## 1985-87 ACTUALS

## 1991-93 BUDGET



## 1995-97 FORECAST

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The 1991 legislature's actions provide an ample demonstration of the impact of these Federal mandates both within the Medicaid program itself and on other program areas. As indicated in the last section, Oregon eliminated both optional services (dental coverage for adults) and optional groups such as medically needy nonpregnant adults. Oregon is similar to other States in trading off one set of Medicaid services or options against the Federal mandates. The Federal constraints have also forced differential treatment of provider groups, with providers covered under the Boren amendment receiving relatively good treatment. The 1991 Oregon Legislature approved the settlement of a \$27.7 million Boren Amendment suit by hospitals at the same time that other providers were not receiving any adjustment for anticipated inflation.

The impact of Medicaid mandates has, however, gone far beyond the issue of priorities within the program. Human resource priorities in other areas have been affected by the rapid and phenomenal growth rate. The areas hardest hit are those which are totally State priorities (people served by programs which have no entitlement status) such as the mentally ill and many services to children or nonmandated services to entitlement recipients. In its 1991 budget, the legislature approved reductions in Emergency Assistance and shelters for the homeless, JOBS services to ADC recipients above the Federal mandates for participation, Cost of Living allowances for ADC recipients, community services to the adult mentally ill, services in State psychiatric hospitals, early intervention services to mentally ill children, and significant administrative reductions to the State human services agency. A complete listing of the reductions in human services is included as appendix, item 6. Although one could argue causal relationships, Medicaid mandates have decreased State flexibility and, when faced with decreased revenues from either economic changes or situations such as Oregon's property tax limitation measure, nonmandated services bear the burden.



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## OREGON'S REVENUE AND EXPENDITURE TRENDS

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Oregon's economy has done well in recent years compared to the national experience. Oregon's General Fund revenues increased 10.7 percent in 1987-89, 24.4 percent in 1989-91 and are anticipated to be up 20.9 percent in 1991-93. These increases, however, are about one-half the increase in Medicaid for the same period. Worse, the State's General Fund increases are projected to slow dramatically in 1993-95 (12.9 percent) and 1995-97 (11.9 percent).

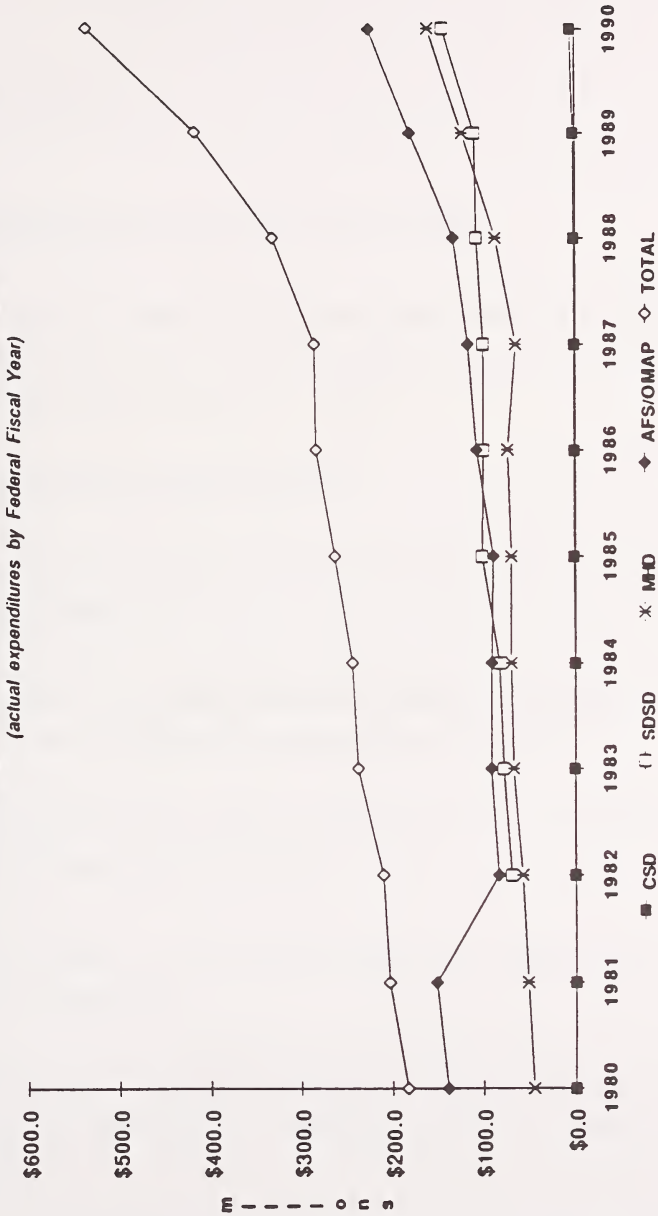
Add to this the changing demographics of Oregon, which impacts expenditures directly. Although the "poor" as a total group may not be growing, Oregon is similar to the Nation in the growth of seniors (particularly +85) and in increasing social trends of concern (such as births to single women, drug-addicted infants, and teen pregnancy). These trends will cost money and, combined with the property tax replacement requirements of Ballot Measure 5, may produce a major fiscal crisis.

It may be that the legislature will raise revenues to stem this pending crisis, but currently the public is demanding tax relief and wiser expenditure of existing dollars. The programs which will bear the greatest burden in such a reduction scenario are State priorities funded by State general funds. Many of these either serve vulnerable populations (mentally ill) or are the programs designed to prevent problems (public health, family support services).



APPENDIX, ITEM 1

DEPARTMENT OF HUMAN RESOURCES  
TITLE XIX PROGRAM EXPENDITURES







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## **APPENDIX, ITEM 2**

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### **Federal Mandates 1986-91**

#### **Omnibus Budget Reconciliation Act of 1986**

- Optional medical coverage of pregnant women and children under age 6 with incomes under 100 percent of the Federal Poverty Level (FPL) Oregon implemented Nov. 1, 1987.

#### **Omnibus Reconciliation Act of 1987**

- Mandatory medical coverage of children through age 6 who meet ADC income standards.
- Optional ability to speed up coverage of pregnant women and children under age 6 with incomes under 100 percent of the FPL.
- Optional medical coverage of pregnant women and children under age 1 up to 185 percent of the FPL.
- Mandatory identification of disproportionate share hospitals and increased reimbursement.
- Nursing Home Reform which increased the requirements for nursing homes and required relocation or additional services for clients of MHDDSD.

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## **Medicare Catastrophic Care Act of 1988**

- Mandatory State payment of Medicare cost sharing for Medicare beneficiaries below 100 percent of FPL.
- Mandatory State coverage of pregnant women and infants below 100 percent of the FPL.
- Prohibition to States on reduction of payment standards.

## **Family Support Act of 1988**

- Prohibition to States on requiring clients to accept a job that reduces their net income level or requiring job or training over 20 hours when the youngest child is between ages 3 and 6.
- Mandatory JOBS programs for the States meeting certain participation and other requirements. (Oregon's commitment to employment has meant that the Federal Government does not completely supply matching funds at our level of effort.)
- Mandatory expansions in daycare and medical coverage for persons transitioning from cash assistance for 12 months.
- Mandatory participation in ADC for two-parent unemployed families.

## **Omnibus Reconciliation Act of 1989**

- Mandatory medical coverage up to 133 percent of the FPL for pregnant women and children up to age 6.

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- Mandatory expansion of medical services to eligible children to provide any necessary medical treatment whether or not that service is included in the State's plan.
  - Nursing Home Reform additional amendments on assessments and quality of care.

### **Omnibus Reconciliation Act of 1990**

- Mandatory medical coverage of all children below 100 percent of FPL born after September 30, 1983, up to age 19 (coverage phases in 1 year at a time).
- Mandatory increases in Medicare cost sharing phased in up to 120 percent of FPL in FY 1995.
- Mandatory use of outreach locations for Medicaid eligibility other than welfare offices.
- Provision of national rebate contracts for drug savings.



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## APPENDIX, ITEM 3

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### The Oregon Health Plan

The mounting crisis in health care costs and access is of growing national concern. There are a number of factors at the root of the problem.

- **There is no standard of health care available to everyone.** Over 32 million Americans don't have health insurance. Many others face the loss or reduction of employment-based coverage.
- **These uninsured Americans are not getting their basic health care needs met on a day-to-day basis.** Without consistent access to primary and preventive care, they are developing painful and serious illnesses which require expensive hospital care, too often resulting in otherwise preventable disability and death.
- **The high costs of this specialty care are shifted to paying customers,** driving insurance premiums higher in a vicious spiral of inflation which makes coverage unaffordable to more and more Americans.
- **Adding to this inflation and further eroding affordable coverage** are the billions of dollars spent on ineffective and inappropriate medical treatments and expensive technologies.
- **States are sinking under the financial burdens of health care inflation and Federal Medicaid mandates.** In addition to these



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constraints, many States are experiencing an economic downturn at the same time that Federal assistance is being reduced. In response:

- States redefine eligibility standards and reduce the number of Medicaid recipients.
- States reduce provider reimbursements to inadequate levels. A growing number of poor people who have a Medicaid card cannot find providers to treat them.

As a result, a growing number of people from all walks of life are going without needed care. Unfortunately, there exists neither a clear Federal health care policy nor a consensus on how to achieve one.

Oregon has reached consensus and taken action.

Over the past 4 years, a broad coalition of business, labor, consumer, and provider groups developed a comprehensive plan to address these problems and provide health care coverage to *all* Oregonians.

The Oregon Health Plan is an equitable, clinically responsible, and publicly designed program to provide universal access to quality care at an affordable price. It contains the essential elements of a fair and successful program for universal health coverage. The Oregon Health Plan:

- **Provides equity** by ensuring everyone access to a publicly defined standard of basic health coverage.
- **Emphasizes effective preventive and primary care.**

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- **Promotes access to that primary and preventive care in the appropriate setting for a clinic or doctor's office, thus reducing preventable complications and unnecessary hospital expenses.**
  - **Delivers care through HMO-style managed care systems which ensure timely access to coordinated care. Prepaid enrollment further promotes efficiency and cost-savings.**
  - **Prioritizes health care services to control spending on ineffective and unnecessary procedures.**
  - **Reduces the "cost-shift" by eliminating uncompensated care and reimbursing providers at reasonable rates.**

## Components

Three bills which form the heart of the Oregon Health Plan were signed into law in 1989.

- **SB 27 extends Medicaid coverage to all Oregonians living below the Federal Poverty Level (FPL) and sets up a process to prioritize health services. The prioritized list used in conjunction with the State budget process defines the Standard Benefit Package of care available to all Oregonians, whether they are covered under Medicaid or through private insurance.**
- **SB 935 requires all employers to provide at least the Standard Benefit Package to all permanent employees and their dependents.**

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- **SB 534 establishes a high-risk pool** to cover those denied insurance due to pre-existing medical conditions.

## **Development**

Oregonians from all walks of life invested over 25,000 volunteer hours to help develop the first public process ever used to prioritize health care services.

In February of 1991, after 18 months of deliberation, an 11-member physician/consumer group, the Health Services Commission, completed the first list of health care services prioritized according to their relative benefit to the entire population. That prioritization was based on the most current clinical information and on publicly expressed social values.

Oregon lawmakers then heard public testimony on how much of the prioritized list should be included in the Standard Benefit Package. Prohibited from altering the order or context of the list, lawmakers defined the benefit package in June 1991 and appropriated additional revenue to implement the program.

## **Benefit Package**

Under the Standard Benefit Package, Oregonians are guaranteed diagnostic services, treatment for life-threatening conditions, maternity care, regular checkups, treatment for most childhood illnesses, immunizations, preventive care, treatment for accidents and injuries, most organ transplants, and dental care. All health services through line 587 of the possible 709 items will be covered. Items not included in the Standard Benefit Package consist of

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treatment for minor and self-limiting conditions, futile care, and other care that is generally less effective.

## **Additional Components**

Oregon lawmakers recently passed additional measures which restructure the small-group health insurance market, expand the scope of the program by adding senior and disabled citizens in 2 years, and integrate mental health and chemical dependence services into the benefit package.

- **SB 44 sets up the process to integrate medical services for the aged and disabled into the prioritized list and Standard Benefit Package in 1993.**
- **SB 1076 guarantees small-business owners and their employees an opportunity to purchase an affordable and renewable package of health care similar to the Standard Benefit Package offered to the Medicaid population.**
- **It integrates mental health and chemical dependency services into the prioritized list and Standard Benefit Package in 1993 and places price controls on small group insurance premiums.**
- **SB 107 establishes the Health Resources Commission to develop methods for controlling unnecessary costs associated with the use of medical facilities, technologies, and services.**

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## **Current Status**

To implement the Oregon Health Plan, the State must receive waivers of Federal rules to expand and modify coverage under Medicaid. A decision on these Oregon-specific waivers is expected by January of 1992. Based on that decision, Oregon will then begin its 5-year demonstration of the Oregon Health Plan on July 1, 1992.

## **Ongoing Process**

The Oregon Health Plan provides an ongoing public process to guide funding decisions affecting health and to ensure that the most effective health services are offered to everyone. The Health Services Commission is charged with updating the prioritized list of health services every 2 years to include the:

- latest health outcomes research;
- best information available from practicing clinicians; and
- public health care values as expressed in town hall meetings, surveys, and public deliberations.

Commissioners will report again in July 1992; this report will guide legislative action during the 1993 session. Oregon lawmakers will publicly balance the need for medical care against other social needs to ultimately deliver the greatest level of health possible to all Oregonians.

Oregon's decisions on the allocation of resources for health will be explicit and public. Accountability for such decisions, and the effects of these decisions on the lives of Oregonians, will be inescapable.

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## The Oregon Health Plan: Timeline

Spring 1987	Legislature approves Medicaid budget which covers additional low-income people but eliminates payments for most organ transplants
January–September 1988	Various legislative interim committees debate proposals to reinstate Medicaid funding for transplants
1987–88	Oregon Health Decisions holds Citizens Health Care Parliaments around the State to develop principles, guidelines, and priorities for fairly allocating health care resources
July 1989	<p>Oregon Health Plan signed into law (Senate Bills 27, 935, 534)</p> <ul style="list-style-type: none"><li>• SB 27 expands Medicaid to all Oregonians below the Federal Poverty Level and sets up the prioritization process to define the Standard Benefit Package</li><li>• SB 935 requires employers to provide the Standard Benefit Package to all permanent employees and their dependents</li><li>• SB 534 establishes a high-risk pool to cover those denied insurance because of a pre-existing medical condition</li></ul>



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August 1989	11-member Health Services Commission (HSC) appointed
September 1989– February 1991	HSC uses a combination of scientific data and social values to develop its methodology and define and rank 709 health condition/treatment pairs
February 29, 1991	Commissioners finalize the prioritized list of health services (list)
February–April 1991	Actuaries determine the rates necessary to cover the costs of services on the list
May 1, 1991	HSC submits its final report, including the list, actuary report, and recommendations to the Governor and Legislature
June 1991	Legislature votes funding which defines the Standard Benefit Package
	Legislature passes additional measures to:
	<ul style="list-style-type: none"><li>• restructure the small-group health insurance market;</li><li>• add senior and disabled citizens to the Oregon Health Plan; and</li><li>• integrate mental health and chemical dependent services into the Prioritized List.</li></ul>

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Summer 1991	Oregon submits application for waivers of Federal law to Health Care Financing Administration (HCFA) and seeks Congressional approval
Fall/Winter 1991-92	HCFA approves waivers for Oregon to expand who it covers and modify what it covers under Medicaid
July 1, 1992	Oregon begins its 5-year demonstration of the Oregon Health Plan upon receipt of waivers of Federal law

## The Oregon Health Plan: Facts

- Approximately 450,000 Oregonians have no health insurance—18 percent of the State's population.
- 120,000 are poor but do not qualify for Medicaid. Poor women with children do not automatically qualify. Single adults and childless couples do not qualify.
- 300,000 are uninsured workers, their dependents, and the "high-risk" uninsured; 65 percent of Oregonians without insurance are from families in which at least one member has a job; 52 percent are adults aged 18-65; and 48 percent are children under 18.
- The number of uninsured Oregonians is increasing 5 percent annually.
- Of those with health insurance, 230,000 have inadequate coverage which does not meet basic health care needs.

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- Many Oregonians face the loss or reduction of coverage because of out-of-control costs. The price for health care is growing at twice the rate of inflation. Oregonians spent \$6 billion on health care in 1989—three times the amount they paid in State income taxes.
  - Approximately 305,000 poor Oregonians receive Medicaid, the Federal/State program to provide health coverage for the poor.
  - Women and children make up over half the approximately 120,000 poor Oregonians not covered by Medicaid.
  - Over the past 6 years, Oregon's Medicaid health care budget has nearly tripled, while the number of people it covers has grown by just over half.

July 1, 1991

FOR IMMEDIATE RELEASE

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## OREGON FINALIZES PIONEERING HEALTH CARE PLAN

In the final hours of the 1991 session, Oregon lawmakers made a commitment to the 450,000 Oregonians without health insurance by defining the benefits offered under Oregon's pioneering health care plan. The Oregon Health Plan, passed 2 years ago, assures all Oregonians access to the health care system and provides them with a comprehensive package of effective medical care.

The Standard Benefit Package defined by the Legislature forms the core of the Oregon Health Plan. The package will be provided to all low-income

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Oregonians through Medicaid with Federal approval and will be offered by employers to their employees and dependents by July 1995.

"We've kept our promise to create a standard of health care that every Oregonian can count on," said Governor Barbara Roberts. "450,000 Oregonians have been forced to seek expensive emergency care as a last resort, often when they have become so sick their conditions are life threatening."

The Legislature, in determining the benefit package, used a prioritized list of medical services prepared over an 18-month period by a physician/consumer group, the Health Services Commission.

"Oregon wants to provide those medical services which are most effective. This ensures that Oregonians will receive the primary and preventive care needed for maintaining health and avoiding the suffering and cost associated with more serious illnesses," explained Senate President John Kitzhaber, a physician and chief author of the Oregon Health Plan. "The Legislature heard public testimony and decided the benefit package should include all health services through line 587 of the possible 709 items on the list."

"This constitutes a good, comprehensive benefit package which covers the vast majority of those services needed by persons seeking care," Kitzhaber added.

Services guaranteed under the Standard Benefit Package include: regular checkups, treatment for most childhood illnesses, treatment for accidents and injuries, immunizations, treatment for life-threatening conditions, maternity care, most organ transplants, dental care, and preventive care such as mammograms and other early detection screenings.

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"Under the current Medicaid system, a woman can only be covered for medical care if she loses her job or gets pregnant," explained Governor Roberts. "Under the Oregon Health Plan, she can continue working and be assured of that care."

House Speaker Larry Campbell said, "The Legislature provided significant additional funding to cover the first year costs of the Oregon Health Plan, beginning July 1, 1991. This assures that we will begin to cover an additional 120,000 poor Oregonians who cannot qualify under the constraints of the current Federal/State Medicaid program."

Oregonians now on Medicaid will not be receiving some services under the Oregon Health Plan which Medicaid now covers. These include treatment for illnesses which heal on their own such as viral sore throats and colds; conditions which respond to applying an ointment or changing a diet such as non-fungal diaper rash and food poisoning; and treatments which generally are not seen as effective such as surgery for low-back pain and heroic but futile measures.

However, under the Oregon Health Plan, Medicaid recipients will gain services such as hospice care and routine physicals and dental care for adults.

According to President Kitzhaber, "The Oregon Health Plan addresses the needs of all the uninsured, not only those on Medicaid. It also benefits 300,000 uninsured Oregonians, most of whom are women and children, by requiring that employers provide this benefit package to permanent employees and their dependents by 1995."

"In addition we have restructured the small-group health insurance market which will make basic health insurance more affordable to small businesses,"

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Kitzhaber went on to add. He cited legislation requiring insurance companies to cover all small employers, to cover all pre-existing conditions, and to limit the premium costs charged to small businesses.

"Not only am I pleased that this plan will provide care to those in need," said Speaker Campbell, "but it also will have a significant impact on the current system where the costs of uncompensated care are passed on to businesses and other payers.

In other moves, the Legislature expanded the scope of the program by adding senior and disabled citizens to the Medicaid plan by October 1993. It will also add mental health and chemical dependency services to the package at that time.

With the definition of the Standard Benefit Package, Oregon will now submit its waivers request to the Health Care Financing Administration. The State is asking for waivers of Federal rules to expand who it covers and modify what it covers under Medicaid. Those waivers are expected by the winter of 1992. Oregon would then begin its 5-year demonstration of the Oregon Health Plan on July 1, 1992.

## Care Oregon Will Provide

Preventive and Primary Care including:

- medical examination to determine diagnosis
- maternity care
- newborn care
- immunizations



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- well-child exams
  - preventive dental care
  - routine physical exams

Access to Care When Sick including:

- pneumonia
- appendicitis
- broken bones
- burns
- head injuries
- rheumatic fever
- asthma
- diabetes
- epilepsy
- cancers: such as breast, skin, stomach, and other treatable cancers
- chest pain due to heart disease
- ulcers
- kidney stones
- bone marrow transplant for certain leukemias
- glaucoma
- ear infection
- liver transplants for children with biliary atresia
- spinal deformities
- shoulder repairs
- heart bypass
- AZT and treatment for opportunistic infection of HIV disease

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Patients will receive necessary ancillary services such as hospital care, prescription drugs, and medical equipment and supplies necessary for successful treatment of those conditions covered.

## **Treatments Oregon Will Not Provide**

Conditions which get better on their own, including:

- dizziness
- viral hepatitis
- benign cyst in the eye
- common cold
- infectious mononucleosis
- viral sore throat
- non-vaginal warts
- minor head injury—bump on head

Conditions where a "home" treatment is effective (applying an ointment, staying off a painful leg, applying hot packs, drinking plenty of fluids, soft diet) including:

- sprains
- styne
- wrestler's ear—bruise
- dry tendon
- canker sores
- hives
- food poisoning
- non-fungal diaper rash

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Conditions where treatment is not generally as effective or futile and heroic measures, including:

- surgery for low back pain
- transplants for simultaneous kidney/liver failure\*
- TMJ (temporomandibular joint)
- severe brain injury\*
- liver transplant for alcoholic cirrhosis\*
- child born with numerous cysts on the lung\*
- aggressive medical treatment for end-stage cancers/HIV disease\*
- aggressive medical treatment for extremely premature babies\*

Note: Comfort care (e.g., pain management and hospice care) is provided for \* items.

Cosmetic:

- lymph gland swells due to excess fluid
- benign skin tumors
- non-toxic goiter—swollen thyroid

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## APPENDIX, ITEM 4

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### Medical Insurance Pool Board

#### Objectives

Increase access to health insurance for high-risk individuals who are denied medical insurance for health reasons.

#### Programs or Activities

**Benefit Package.** Review benefit levels and client demographic data to assure benefits meet the needs of applicants, and modify the benefit package as needed. Monitor third-party agreement costs and membership composition. Review underwriting practices and determine how the high-risk pool can be coordinated with the small business pool. Determine enrollment limitations, eligibility requirements, deductibles, co-insurance factors, exclusions and limitations, and premium rates.

**Third-Party Agreement.** Select one or more insurers through a competitive bidding process to carry out the administrative functions of the insurance program for 3-year periods. The administering insurer performs all eligibility and administrative claims functions, establishes a premium billing procedure, pays benefits in a timely manner, and submits regular reports to the Board.

**Eligibility.** Determine eligibility requirements, evaluate eligibility, and monitor and control enrollment to contain costs.

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**Assessment.** Determine the amount of funds needed to pay expenses of the Pool and cover Pool losses in a timely manner and assess Oregon health insurer and reinsurers to collect funds needed. Make subsequent assessments to cover Pool losses.

**Medical Insurance Pool.** Manage a major medical expense coverage program and provide for the smooth functioning of the program to avoid undue financial impact on the State and private insurers. Build management information systems; monitor performance and workload; and adopt insurance policies, rules, and procedures.

## **Recommended Program Level**

The recommended budget funds the insurance program for 24 months. The program began serving participants in July 1990 and was phased in over 18 months in 1989-91. The recommended budget will allow the number of participants to increase by 1,150 in 1991-93.

## **Program Discussion**

The Board was established as a separate agency during the 1989 legislative session to provide standard health insurance coverage to high-risk individuals who have been denied medical insurance for health reasons. It is estimated that there are approximately 15,000 to 20,000 eligible people in Oregon.

The Board has adopted rules and developed two benefit plans. The Board selected Blue Cross Blue Shield through a competitive bidding process to administer the program for 3 years. Enrollment began on July 1, 1990, with a target of 1,000 participants during 1989-91. The recommended budget will increase the number of participants to 2,150.

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## APPENDIX, ITEM 5

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### STATE OF OREGON

Legislative Revenue Office  
140 State Capitol Building  
Salem, Oregon 97310-1347  
Legislative Revenue Officer  
James R. Scherzinger  
Area Code 503  
378-8873

### IMPACT OF MEASURE 5

1.5 percent Property Tax Limit

Research Report 3-90  
September 6, 1990

### Introduction

On November 6, Oregonians will again vote on a property tax limit. If voters approve, Measure 5 will make major changes in Oregon's tax system. This report contains:

- a general description of Measure 5;
- a more detailed description of Measure 5's effect on the existing property tax system;
- a forecast of the statewide impact on the State and local taxing districts;



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- a summary and analysis of the assumptions used to prepare this report; and
  - a forecast of the effect on each school district in the State.

## **Description**

Measure 5 is an initiative to amend the Oregon Constitution. It limits the total taxes and government charges on each property in the State based on the property's real market value.

## **Tax Categories**

Measure 5 divides property taxes and charges into two categories: (1) school taxes and charges and (2) non-school taxes and charges. Schools include all public school from pre-kindergarten through college and graduate school. Non-schools include everything else.

The taxes of ad valorem property tax districts would generally fall into these categories as shown in table 1.

## **Limit Phase-in**

At the end of a 5-year phase-in, Measure 5 limits total school taxes and charges to \$5 per \$1,000 of each property's real market value and total non-school taxes and charges to \$10 per \$1,000. The limits during the phase-in are shown in table 2. Note the \$10 non-school limit takes effect in the first year, while the school limit phases down from \$15 in 1991-92 to the \$5 permanent limit in 1995-96.

**Table 1**  
**Ad Valorem Property Tax Districts**

School	Non-school
Common Schools	County
Union High	City
Education Service	Rural Fire
Community College	Port
County School Fund*	Urban Renewal
	Road
	Park
	METRO
	Other

\*If separately levied.

**Table 2**  
**Measure 5 Limits for Each \$1,000 of Property's Value**

Fiscal Year	School Taxes	Non-School Taxes	Total
1991-92	\$15.00	\$10.00	\$25.00
1992-93	12.50	10.00	22.50
1993-94	10.00	10.00	20.00
1994-95	7.50	10.00	17.50
1995-96	5.00	10.00	15.00

Measure 5 sets these limits in the Oregon Constitution. They could not be increased by local voters.

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## **Taxes and Charges Covered by Limit**

The limits in Measure 5 generally apply to all State and local taxes and charges on property. However, the limits do not apply to:

- charges incurred for the cost of providing goods or services requested by an owner;
- assessments for capital construction that provide a special benefit to the property and that can be paid off over at least 10 years;
- taxes to repay bonded debt authorized by the State constitution;
- taxes to repay existing bonded debt for capital construction; and
- taxes to repay new bonded debt for capital construction if approved by voters.

Later sections in this report cover this area in more detail.

## **Reducing Taxes to the Limits**

If taxes and charges levied on a property exceed the school or non-school limits, Measure 5 reduces each tax and charge proportionately. The school and non-school proportions are figured separately. The reductions may vary from property to property.

Table 3 shows the reduction for two example properties. The table uses the permanent rate limits: those that apply after the 5-year phase-in. For simplicity, the table assumes only a few districts levy a property tax on each

property and that there are no other covered taxes or charges on either property.

**Table 3**  
**Example of Property Tax Reductions**  
**After Full Phase-In of Measure 5, 1995-96**

	Property A \$100,000 Value				Property B \$100,000 Value			
	Current		Measure 5		Current		Measure 5	
	Rate (\$)	Tax (\$)	Tax (\$)	% Cut	Rate (\$)	Tax (\$)	Tax (\$)	% Cut
County	4.00	400	320	20	4.00	400	400	0
Port	1.50	150	120	20	1.50	150	150	0
City	7.00	700	560	20				
Nonschools	12.50	1250	1000	20	5.50	550	550	0
K-12 School	18.00	1800	450	75	10.50	1050	420	60
Community College	2.00	200	50	75	2.00	200	80	60
Schools	20.00	2000	500	75	12.50	1250	500	60
Totals	32.50	3250	1500	54	18.00	1800	1050	42

For Property A, the total tax rate for non-schools under current law is \$12.50 per \$1,000 of property value. This rate on \$100,000 value produces total non-school taxes of \$1,250. This exceeds the Measure 5 limit of \$1,000 (\$10 per \$1,000 of property value). To get the taxes down to the limit, the tax going to each non-school district is reduced by the same percentage. In this case, the required percentage reduction is 20 percent.

Similarly, the school taxes on Property A exceed the \$5 per \$1,000 limit. So the taxes to the K-12 school and the community college are each reduced

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75 percent to comply with the limit. Note the school and non-school reductions are figured separately. So the reductions vary between the two categories.

Property B is not in a city. The remaining non-school taxes do not exceed the limit, so Property B's non-school taxes are not cut. Property B is in a different school district, but the total school taxes still exceed the limit. The required school cut is 60 percent.

Note the tax reductions also vary from property to property. Although both properties pay \$400 to the county under current law, Property A's county taxes drop to \$320 while Property B's stay at \$400. Similarly, Property A's community college taxes drop to \$50 while Property B's drop to \$80.

## **State Replacement of School Losses**

During the first 5 years, Measure 5 requires the State General Fund to replace any revenue lost by schools due to these limits. However, the measure allows the State to limit its replacement so that total school revenue from property taxes and State replacement does not grow by more than 6 percent a year. The State is not required to replace revenue lost by non-schools.

## **Real Market Value**

The limits apply to the real market value of each property. For practical purposes, real market value is the same as true cash value: the value at which most properties are currently assessed.

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There is one potential difference between real market value and current assessment practices. Currently property taxes are levied on each property's value as of January 1 of the previous year. For example, property taxes for the 1991-92 fiscal year are based on property values as of January 1, 1991. The Measure 5 limits apply to real cash value "during the period for which the property is taxed," which generally would be a year later than current practice.

## **Effect on Non-Ad Valorem Taxes and Charges**

### **Definition of Tax**

Measure 5 defines "tax" to be "any charge imposed by a governmental unit upon property or upon a property owner as a direct consequence of ownership of that property except incurred charges and assessments for local improvements."

This definition and the further definitions of "incurred charges" and "local improvement" can be interpreted in different ways. There is no doubt, however, that "tax" includes more taxes and charges than are commonly termed property taxes. What most people call "property taxes" are really "ad valorem taxes:" taxes based on the value of the taxed property. Although the precise scope is uncertain, Measure 5 includes many taxes and charges beyond ad valorem taxes.

Some examples of non-ad valorem taxes that could be limited by Measure 5 are registration and licensing fees, forest protection assessments, underground storage tank fees, taxes in lieu of property taxes, special district assessments, economic improvement district assessments, system development charges,



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and seepage charges. For a discussion of Measure 5's definition of taxes, see the Attorney General's opinion (Question 3).

## **Implications of Broad Definition**

One implication of the broad definition is administrative. Non-ad valorem taxes are currently imposed by many different mechanisms and at different times of the year. No process currently identifies the total taxes and charges on a property. Such a process is needed to implement Measure 5. The most likely procedure would be to certify every covered tax and charge to the county assessor. The assessor would add these taxes to the regular ad valorem taxes, compare the totals to the limits, and proportionately reduce taxes that exceed the limits.

The broad definition also has revenue implications. Most, if not all, non-ad valorem taxes fund non-school programs. Thus, they fall under the \$10 per \$1,000 non-school limit. For any particular non-ad valorem tax, the effect depends mainly on whether the tax is on a property that also pays ad valorem taxes.

If the property is exempt from ad valorem taxes, there is likely to be much more room within the \$10 limit to impose the non-ad valorem tax. For example, automobiles are exempt from ad valorem taxes. So most auto registration fees are likely to fall within the limit and total collections may not be greatly affected.

If the property is subject to ad valorem taxes, there is likely to be much less room within the limit, and revenues from both the ad valorem and the non-ad valorem taxes are likely to be reduced.

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## **Effect on Ad Valorem Taxes**

### **Current Levy Process Unchanged**

The State constitution currently limits ad valorem property tax levies. Under Article XI, section 11, the permanent levy (called a "tax base") of each district can grow by up to 6 percent a year. Voters can approve higher temporary levies or, once a year, a higher permanent levy.

Each year, taxing districts adopt a budget and certify a levy within the constitutional limits to the county assessor. The assessor, who has independently determined the value of each taxable property, calculates the tax rate on each property. On any particular property, the assessor calculates a number of taxes: one for each district the property is located in. The assessor adds these taxes to get a total tax on the property.

Measure 5 does not change the existing ad valorem property tax levy limits. Nor does it change any of the process outlined above. Measure 5 simply adds a new limit at the end of the process. If the total school or non-school taxes on a property exceed the measure 5 limits, then the taxes on that property are reduced proportionately. The existing budget and levy process does not change, but each district's levy simply produced less money.

### **Uniformity Overridden**

The State constitution (Article I, Section 32) requires all taxes to be levied uniformly on the class of subjects. For property taxes, uniformity has meant all property of the same class in a district must pay the same tax rate.

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Measure 5 overrides this requirement. The example on page 3 shows this. After the Measure 5 reductions, Property A pays an effective tax rate of \$3.20 to the county and 50¢ to the community college, while Property B pays \$4.00 to the county and 80¢ to the community college.

Measure 5 overrides uniformity only to the extent needed to conform to the Measure 5 limits and only through the proportional reduction process established by Measure 5. It does not repeal Article I, Section 32. The current budget and levy processes described above must continue to use uniform tax rates to calculate the initial taxes on each property.

## **Higher Taxes for Some?**

Under current law, the assessor calculates a district's tax rate by dividing the certified levy by the district's total assessed value. This process produces a uniform tax rate and ensures the total taxes imposed do not exceed the district's constitutional levy limit.

Under Measure 5, as described earlier in this section, this process will often impose less total taxes than the levy limit.

In the opinion of the Attorney General (Question 10), the Legislature could change current law to calculate a higher tax rate as long as the higher rate would not impose total taxes greater than a district's levy limit. Using a higher rate would:

- Increase taxes on properties that otherwise would be below Measure 5's limits. In the example on page 3, if the county and port rates were increased, Property B's taxes would increase. Property A's total taxes would not increase, because they are already at the limit.

- 
- Increase the district's proportional share of total taxes. If the county and port rates were increased but the city rates were not, the county and port would get a greater share of Property A's taxes.

For more on potential revenue effect allowing higher rates, see page 363.

## **Competition Among Taxing Districts**

As described earlier, Measure 5 does not change current budget and levy procedures. Thus, a district may still ask voters to approve new tax levies. If approved, the new levy would not increase taxes on properties already at Measure 5 limits. It would, however, increase the district's proportional share of the limited taxes. This dynamic creates an unstable and confusing competition between taxing districts for limited funds. It is likely the legislature would adopt laws to apportion levying authority to mitigate this competition.

## **Specially Assessed and Partially Exempt Property**

Current law taxes some property at less than its market value. The most common examples are farm land, forest land, open-space land, historic property, and property receiving a veteran's exemption.

Measure 5 does not change these special assessments or partial exemptions. However, the Measure 5 limits are based on the property's real market value, not the specially assessed or partially exempt value.

This means specially assessed or partially exempt property may get little or no tax reduction under Measure 5. For example, suppose Property B in the

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example on page 3 is a farm whose specially assessed value is \$100,000 and real market value is \$300,000. As table 4 shows, the school limit on Property B would now be \$1,500 and Property B would get no tax reduction.

**Table 4**  
**Farm B**  
**\$100,000 assessed value**  
**\$300,000 real cash value**

	Current	
	Rate	Tax
K-12 school	\$10.50	\$1050
Community College	2.00	200
Total school	\$12.50	\$1250
Measure 5 school limit*		\$1500

\*\$5 per \$1,000 X \$300,000.

## Urban Renewal Property

### Current Law

Urban renewal districts do not determine a levy and tax rate using the process described earlier for regular taxing districts. Instead, the assessed value of the urban renewal area is divided into two values: the assessed value and the excess value. The base (or "frozen") value is the value of property in the district when the district was created. The excess value (or "increment") is the growth in value since the district was created.



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The base value is included in the value of taxing districts when the assessor calculates the tax rates for regular taxing districts. The taxes on the base value go to these taxing districts.

Taxes on the excess value go to the urban renewal district. However, the tax rate is not determined by dividing a levy by the excess value. Instead, the assessor simply extends total tax rate determined for the base value on all the value and apportions the taxes on the excess value to the urban renewal district.

## **Effect of Measure 5**

Measure 5 does not change this process. However, Measure 5 limits the total taxes imposed on any property and proportionately reduces these taxes if they exceed the limits.

Suppose Property A in the example on page 3 is in an urban renewal district. Also suppose \$40,000 of Property A's value is base value and \$60,000 is excess value. Table 5 shows the effect of Measure 5's limits.

In the table, the current tax of each regular district is the district tax rate applied to the \$40,000 base value. The current urban renewal tax is the regular district total rate (\$32.50) applied to the \$60,000 excess value. The urban renewal district is not a school; so its taxes must fit within the \$10 non-school limit. Since the real cash value of the property is \$100,000, the non-school limit is \$1,000 and the school limit is \$500. This requires a 59-percent reduction of non-school taxes and a 38-percent reduction of school taxes.



**Table 5**  
**Urban Renewal Property A**  
**\$40,000 base value**  
**\$60,000 excess value**

	Current			Measure 5	
	Rate on Base	Rate on Excess	Tax	Tax	% Cut
County	\$4.00		\$160	\$65	59
Port	1.50		60	25	59
City	7.00		280	114	59
Urban R.		<u>32.50</u>	<u>1950</u>	<u>796</u>	<u>59</u>
Non-schools	12.50	32.50	2450	1000	59
K-12 school	18.00		720	450	38
Community College	<u>2.00</u>		<u>80</u>	<u>50</u>	<u>38</u>
Schools	20.00		800	500	38
Totals	\$32.50	\$32.50	\$3250	\$1500	54

## Caveats

The example assumes all of the urban renewal district's taxes are subject to the Measure 5 limits. If, however, some of the taxes are used to service bonded debt, that portion of the taxes is exempt from the limits. This would increase the amounts going to all of the non-school districts.

The example does not demonstrate how the base and excess values of an individual property are determined. Under current law, these concepts are only applied to district levies, not to individual properties. If Measure 5 passes, the Legislature would have to determine the appropriate method.

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## Statewide Impact of Measure 5

### General Methodology

This report forecasts the revenue lost by each school district in the State over the first 5 years of the measure and estimates the State General Fund cost to replace lost revenue over the next three bienniums. The report also forecasts the statewide total loss of revenue by non-schools in the first year of the measure. These forecasts are based on a number of assumptions. Due to data limitations, not all aspects of Measure 5 could be included in the forecasts. Following the forecasts, the report discusses the potential impact of adjusting some of the forecasts to include more features of Measure 5.

The base data of the forecasts are from the 1989-90 tax year. It is the most recent year of complete property tax data. For 1990-91, school district values were increased by amounts estimated by the county assessor in each county. The average value increase statewide was about 9 percent. School district levies for 1990-91 were updated with actual figures if they were known. All other levies were increased by 7 percent.

From 1991-92 and thereafter, all levies under the current system are assumed to increase 7 percent a year. This is below the long-run average (about 8.6 percent a year since 1969) but about the level of recent increases.

The forecasts make three different assumptions on value increases: 6 percent, 9 percent, and 12 percent. These are growth rates of total values, including any value growth from new construction. The forecasts are very sensitive to increases in value. Measure 5 effectively converts much of the State into a rate-based tax system. Increases in property value will increase taxes and revenue. Also, Oregon appears to be entering a period of renewed

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economic growth. Value growth over the next few years is highly uncertain. Nine percent is about the longrun growth of value (average of 8.9 percent a year since 1967) and is considered the base forecast. The other two growth rates show the impact of varying the growth rate.

## **Impact on Schools**

Table 6 summarizes Measure 5's impact on schools. Assuming school operating levies would grow 7 percent a year under current law, and assuming property values grow 9 percent a year, Measure 5 will reduce school property taxes by \$231 million in the first year of the measure (1991-92) and \$1.53 billion in the fifth year (1995-96), when the \$5 limit is fully phased in.

Of these amounts, the State would be required to replace \$215 million in the first year and \$1.42 billion in the fifth year. These numbers are lower than the forecasted loss because current law operating levies are assumed to grow 7 percent a year, while the State is only required to replace losses from levy growth up to 6 percent a year.

The table shows value increases significantly affect the results. In the last 3 years of the phase-in, each 3-percent increment in compounded annual value growth decreases the loss from Measure 5 by about \$100 million per year. Note every additional tax dollar generated by more rapid value growth directly reduces State replacement cost. The net school loss estimate is not affected by value growth.

Table 7 shows State replacement cost by biennium. State cost declines with more rapid value growth. But even with relatively rapid growth, the State cost is very large. Note both of these tables show forecasts for 1996-97 even

Table 6a  
Impact of Measure on School  
6% Annual Value Increase

	Current Law			Measure 5			School Net Loss
	Total Assessed Value	Oper. Taxes	Av. Tax Rate	Oper. Taxes	Eff. Tax Rate	Tax Reduction	
1990-91	\$94.8	\$1,612	\$17.00				
1991-92	100.5	1,725	17.16	1,462	14.54	263	247
1992-93	106.5	1,845	17.32	1,323	12.42	522	488
1993-94	112.9	1,974	17.48	1,132	10.02	843	788
1994-95	119.7	2,113	17.65	904	7.55	1,209	1,131
1995-96	126.9	2,261	17.81	641	5.05	1,620	1,516
1996-97	134.5	2,419	17.98	680	5.05	1,739	1,607

Table 6b  
Impact of Measure on School  
9% Annual Value Increase

	Current Law			Measure 5				School Net Loss
	Total Assessed Value	Oper. Taxes	Av. Tax Rate	Oper. Taxes	Eff. Tax Rate	Tax Reduction	State Replaced Cost	
1990-91	\$94.8	\$1,612	\$17.00					
1991-92	103.4	1,725	16.68	1,494	14.45	231	215	16
1992-93	112.7	1,845	16.38	1,393	12.36	452	418	34
1993-94	122.8	1,974	16.08	1,227	9.99	747	692	55
1994-95	133.8	2,113	15.78	1,010	7.55	1,103	1,025	78
1995-96	145.9	2,261	15.49	736	5.05	1,525	1,421	104
1996-97	159.0	2,419	15.21	802	5.05	1,617	1,484	133

Table 6c

Impact of Measure on School  
12% Annual Value Increase

	Current Law			Measure 5				
	Total Assessed Value	Oper. Taxes	Avg. Tax Rate	Oper. Taxes	Eff. Tax Rate	Tax Reduction	State Replaced Cost	School Net Loss
1990-91	\$94.8	\$1,612	\$17.00					
1991-92	106.2	1,725	16.24	1,523	14.34	201	185	16
1992-93	118.9	1,845	15.51	1,460	12.28	385	351	34
1993-94	133.2	1,974	14.82	1,327	9.96	647	592	55
1994-95	149.2	2,113	14.16	1,124	7.53	989	911	78
1995-96	167.1	2,261	13.53	842	5.04	1,418	1,314	104
1996-97	187.2	2,419	12.92	943	5.04	1,476	1,343	133



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**Table 7**  
**State Replacement Cost\***

	Value Growth (\$)		
	6%	9%	12%
1991-93	735	633	536
1993-95	1,919	1,717	1,503
1995-97	3,123	2,905	2,657

\*All figures in millions.

though the Measure 5's requirement to replace school losses ends after 1995-96. This is to give an idea of the biennial cost of full implementation of Measure 5, assuming someone will have to replace the losses.

Finally, note the average effective tax rate under Measure 5 appears to be higher than the limit in the last 3 years of the phase-in. This occurs because urban renewal excess values are not included in the assessed value total. If they are included, the average effective tax rate drops below the limit.

## **Impact on Non-Schools**

Table 8 summarizes the effect of Measure 5 on non-schools. Assuming current law levy growth of 7 percent a year and value growth of 9 percent, non-school districts will lose about \$85 million in property tax revenue in 1991-92. Cities lose the most—about \$49 million, a reduction of 13 percent. Urban renewal districts have the greatest percentage reduction—about 20 percent.

**Table 8**  
**Impact of Measure 5 on Non-Schools\***

	Current Law Taxes	6% Taxes	6% Loss	9% Taxes	9% Loss	12% Taxes	12% Loss
Cities	\$377	\$323	\$54	\$328	\$49	\$334	\$43
Counties	255	228	27	231	24	233	22
Special Districts	155	152	3	152	3	152	3
Urban Renewal	44	35	9	35	9	36	8
Total	\$831	\$738	\$93	\$746	\$85	\$754	\$77

\*Figures in millions. Excludes bond levies, except urban renewal.

## Impact on State General Fund

By far the largest impact on the State is the required replacement of lost school revenue shown earlier. There are some other relatively minor impacts. Lower property taxes mean lower deductions on income tax returns, increasing General Fund revenue. Lower property taxes will also reduce the cost to existing State property tax relief programs: The Homeowners and Renters Relief Program (HARRP) and the senior deferral. Table 9 summarizes the impact on the State General Fund. Assuming 9 percent annual growth in assessed value, the cost of replacing school revenue will consume 41 percent of forecasted revenue, leaving \$4.2 billion for other programs. Adjusting for inflation, but not population growth, this represents a 31 percent cut in the current level of appropriations for other programs.

**Table 9**  
**Impact on State General Fund\***  
**Assuming 9% Value Growth**

	1898-91	1991-93	1993-95	1995-97
<b>Revenue</b>				
Current forecast	\$4,596	\$5,208	\$5,914	\$6,956
Income tax feedback		35	82	123
Total revenue	4,596	5,243	5,996	7,079
<b>Expenditures</b>				
School replacement	-	633	1,717	2,905
Relief program savings	-	-7	-17	-29
Total Measure 5 costs	-	626	1,700	2,876
<b>Left for other programs</b>				
Current dollars	4,586	4,617	4,296	4,203
Adjusted for inflation	4,586	4,211	3,523	3,181
<b>MS costs as % of revenue</b>	-	12%	28%	41%

\*Figures in millions. Assumes constant cash carryover. 1989-91 other program costs are actual appropriations. Forecast from Executive Department (September 1, 1990), except 1995-97.

## Average Tax Reduction

Assuming 9-percent growth in total values, Measure 5 will reduce property taxes by an average of 12 percent in the first year (1991-92), rising to an average reduction of 45 percent in the last year of the phase-in (1995-96).

These are averages. Reductions will vary widely. Generally, property currently paying high tax rates will get greater reductions than property currently paying lower rates.

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# Assumptions and Their Impact

Due to data limitation, not all aspects of Measure 5 could be included in the preceding forecasts. This section describes the principal simplifying assumptions and, where possible, estimates the probable statewide effect if the assumption were relaxed.

## Non-Ad Valorem Taxes Not Included

The effect of including non-ad valorem taxes and charges in the limit is not included in the preceding statewide forecasts or the individual school forecasts at the end of this report. This means the forecasts tend to underestimate the revenue loss to non-schools, especially cities.

Table 10 lists some of the taxes and charges that may be limited by Measure 5. There is much uncertainty about the scope of Measure 5's definition of tax. So inclusion on this list does not necessarily mean the tax is definitely covered by Measure 5, nor does exclusion mean a tax or charge is not covered.

Table 10 shows the total revenue currently raised from each source and makes a very rough guess of the amount affected by Measure 5. For taxes on property not currently paying ad valorem taxes, the listed tax will lose the amount listed. For taxes on property also paying ad valorem taxes, the listed tax will not lose all of the amount listed. Some of the loss will be borne by districts levying ad valorem taxes.

Table 10  
Impact of Measure 5 on Non-Ad Valorem Taxes\*

	Gross Revenue	Possible Loss	Affected programs
Property not paying ad valorem taxes			
Timber severance & forest products harvest taxes	\$56	\$43	Schools, counties, spec. districts, forest programs
Motor vehicle registration fees	70	4	Highway Fund
Port in lieu taxes	-	0	
Rural telephone in lieu	0.1	?	Local taxing districts
Electric co-op in lieu	3	?	Schools, counties
Property paying ad valorem taxes			
Special assessment additional taxes	4	most	Local taxing districts
Special district assessments	20	?	Special districts
Amusement device taxes	2	most	State, counties
Forest assessments	2	some	Forest fire protection
Economic improvement assessments	2	most	EID's
Manufactured dwelling assessments	0.2	half	Housing Agency
Underground storage tank fees	0.5	?	DEQ
System development charges	15	most	Cities, counties
Real estate transfer taxes	2	most	Counties
Other	?	?	

\*Figures in millions.

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## Limit Applies to the Value on Tax Roll

The forecasts assume Measure 5's limits apply to the value on the existing tax rolls. This assumption tends to overestimate the revenue loss in two ways. Most importantly, the forecasts apply Measure 5's limits to the reduced value of specially assessed and partially exempt property. Unfortunately, little data exist on the real market value of specially assessed property and no data on the amount of it by school district.

Most of the specially assessed property is farm and forest land. Almost all this property is in rural areas where the non-school rate is already below \$10 per \$1,000. So using a higher value to figure the limit will not affect the non-school taxes on the property.

Using a higher value will affect school taxes. It could reduce the Measure 5 loss by as much as \$22 million a year after the \$5 limit fully phases in. This would reduce State replacement cost by \$44 million in the 1995-97 biennium. Note this does not mean Measure 5 is increasing taxes on farm and forest property; the property is just not getting as much of a reduction as it otherwise would.

The most important partial exemption is the veteran's exemption. Using the real market value to calculate the limit would reduce the school loss by about \$1 million per year after full phase-in and the non-school loss by about \$200,000.

Secondly, current law determines property values as of January 1 of the prior tax year. As described earlier, the measure uses a more current value to figure the limit. In a period of rising values, this value would be higher than is currently used. However, using a more current value may not be practical



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administratively. Also, to the extent properties go down in value, this assumption tends to underestimate revenue loss.

## **County School Fund Not Separately Levied**

The forecasts assume counties will not separately designate the county school fund levy. Measure 5 does not appear to reduce the amount a county is required to contribute to the county school fund, even if a separately designated levy produced less revenue because of Measure 5. So a county would generally choose to separately designate the levy only if it got more revenue. But after full phase-in, the school limit will almost always be tighter than the non-school limit. So few counties would choose to separately designate the levy.

## **Current Law Tax Rates Not Increased**

As described earlier, the measure appears to allow higher tax rates, as long as total taxes (after Measure 5 limits are imposed) are under existing constitutional levy limits. The forecasts assume the legislature does not allow this.

Allowing higher tax rates produces more revenue only if some property is not at the Measure 5 limit. This higher tax rate would generally not reduce the school loss, especially after the \$5 rate phases in.

However, only about 35 percent of the State's property value would be up against the \$10 non-school limit. If the legislature allowed higher non-school tax rates, most of the non-school loss probably could be eliminated. The higher rates would increase taxes on properties in areas currently below the

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\$10 non-school limit, thus tending to create an \$10 effective tax rate across all property in the affected areas.

### Other Assumptions

The forecasts also assume: the State limits its school replacement costs as permitted by the measure; offsets continue to apply to levies, but Measure 5 applies to taxes imposed after offsets; all bond levies on the current tax roll are exempt from Measure 5's limits; and the base proportion of each urban renewal property's total value is the same as the base proportion for the entire code area in which the property is located.

### Impact on Local Schools

Attached to this report are forecasts of the impact of Measure 5 on each school district, education service district (ESD), and community college in the State. The forecasts cover the first 5 years of Measure 5. These forecasts are based on the same assumptions described earlier for the statewide forecasts.

The tables contain four lines of information for each district.

Line 1: The district's estimated net operating property tax levy under current law. The estimate assumes a 7-percent increase in the levy each year from the district's levy in 1990-91. If the district's 1990-91 levy was not known, it was assumed to be a 6-percent increase from its 1989-90 levy.

Line 2: Loss in property tax revenue due to Measure 5 assuming a 6-percent annual increase in property value. The 6-percent annual value increase is

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applied to the county assessor's estimate of value for 1990-91 for each district. To get the total Measure 5 revenue, simply subtract the loss from the current law levy.

Line 3: Loss in property tax revenue due to Measure 5, assuming a 9 percent annual increase in property value. Same as line 2 except value is assumed to grow 9 percent a year.

Line 4: Loss in property tax revenue due to Measure 5, assuming a 21-percent annual increase in property value.

In looking at the tables, please note:

- The loss estimates are not estimates of the amount of State replacement. The State's responsibility to replace lost revenue is limited. Also, the State is apparently only required to replace lost revenue to the system as a whole, not to each individual taxing district. For a discussion of this, please see the Attorney General's opinion (Question 7).
- There is no simple way to adjust the loss estimates for different assumptions of current law revenue. This is because changing the current law levy changes the district's proportional share of the Measure 5 limit. Generally speaking, lowering a district's current law levy will decrease its Measure 5 revenue. However, the district's Measure 5 revenue will go down more if the district is currently getting a small share of total levy and if the total rate is close to the limit. The district's Measure 5 revenue will go down less if the district is currently getting a large share of the total levy and the total rate is far above the limit. Also, changing the current law levy of any

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district changes the Measure 5 revenue of all other districts taxing the same property.



# APPENDIX, ITEM 6

## MAJOR REDUCTIONS APPROVED BY THE 1991 LEGISLATURE

	GENERAL FUND (In Millions)
<b>Reductions in Reimbursement</b>	
Eliminate 2nd year Cost of Living for Clients	\$3.1
Cost of Living at 6.1% instead of 8.5% for Non-foster Care CSD Providers	1.6
Cost of Living for Medicaid Providers (non-hospital)	9.0
Cost of Living for Hospital Outpatient Services	4.1
<b>Administrative Reductions</b>	
Adult and Family Services	\$9.8
Children's Services	1.9
Health	.9
MHDDSD - Central Office	2.5
MHDDSD-Institutional Admin., Supplies and Capital Outlay	3.5
MHDDSD-Local Community Administration	1.4
Senior and Disabled Services- Central	1.4
Senior and Disabled Service-Field	.8
Office of the Director	2.6
<b>Service Reductions</b>	
Reduce Maximum Payment for Emergency Assistance	\$1.3
Reduce Participation in JOBS, Welfare Reform	29.1
Reduce Juvenile Corrections - Picture House, Camp Wages	1.0
Reduce Medically Needy for Elderly and Disabled to Drugs Only	2.6
Eliminate Medically Needy for Non-Pregnant Adults	4.3
Eliminate Adult Dental Services	2.2
Reduce Medicaid Program by 1% (unspecified)	2.5
Reduce Services to the Homeless	.5
Reduce the Self-Sufficiency Program	1.1
Reduce School Based Clinic Funding	.5
Reduce Community Services to the Adult Mentally Ill	1.6
Reduce Early Intervention and Outpatient Services for Mentally Ill Children*	.7
Eliminate One Ward Dammasch State Hospital	1.8
Close Wards at Oregon State Hospital and Develop Community Programs	1.8
Reduce Services to the Lowest Impaired Seniors and Disabled	2.0
Reduce Cash and Medical to General Assistance Clients	1.1
Reduce Mental Health Pilots Projects for Seniors*	.3

\*A reservation of \$300,000 was designated for mental health services to the elderly and children within Emergency Board funds.

Additional information is available on these reductions in the Division detail of Major Budget Issues.





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# **History of the Pennsylvania Medicaid Program: 1986–91**

Robert Bittenbender  
Pennsylvania Senate Appropriations Committee

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## INTRODUCTION

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In Pennsylvania, the Medical Assistance (MA) program has mirrored the experience of other States in the rise of Medicaid expenditures. In FY 1986-87, total actual expenditures for outpatient, inpatient, long-term care facilities, and capitation services amounted to \$2.1 billion. For FY 1991-92, the total amount appropriated for these same programs is \$5.3 billion, an increase of 251 percent over the 5-year period. The percentage share of MA to the State general fund budget has also increased from 9.7 percent in FY 1986-87 to 12.4 percent of State general funds in FY 1991-92.

During the same time period, the number of eligible persons has also increased. The average monthly number of persons eligible for Medical Assistance in FY 1986-87 was 1,233,942. The estimated average monthly number of persons eligible for Medical Assistance for FY 1991-92 is 1,448,791, with the estimated eligibility for April 1992 estimated to reach 1,551,530. As can be seen from the table below, the average monthly number of eligibles over the period declined, reflecting economic conditions in the State, and began to rise in FY 1990-91. The latter increase reflects the impact of both the economic recession and the impact of federally mandated increases in program eligibility.

As the program has grown, emphasis has been placed on containing cost. Services that are reimbursed under a fee schedule (most outpatient services) have largely been held constant, with no fee increases provided. As a result, many service providers complain that fees are inadequate and, in some cases, choose not to participate in the program. The 1991-92 budget finally attempts to address this by providing \$50 million in State funds

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**Medical Assistance  
Average Monthly Eligibility**

Year	Eligibility (\$)
1986-87	1,233,942
1987-88	1,200,550
1988-89	1,187,628
1989-90	1,230,972
1990-91	1,332,200
1991-92	1,448,791

Note: Estimate for April 1992 at \$1,511,530.

(\$100 million total) to increase fees for outpatient services to increase access for Medical Assistance recipients. This initiative will annualize in 1992-93 at \$60 million in State funding (\$120 million total funds).

The major cost drivers have been the inpatient and long-term care appropriations. Unlike services reimbursed under a fee schedule, reimbursements are driven by inflationary cost increases. While the Commonwealth has attempted to control the cost impact by using minimal percentage increases to reflect inflation, this has been a short-term solution. Recent court cases have ruled that payments for inpatient hospital care were insufficient and necessitated substantial increases in inpatient hospital payments.

As a reaction to rapidly increasing costs, the Commonwealth has developed the strategy of using voluntary contributions from providers to offset State costs as well as eliminate the need to reduce program reimbursement and/or services. "Pooling," as it is commonly called, has been used in inpatient services, and, if the State plan amendment now under Federal review is

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approved, voluntary contributions will also be used for long-term care services. Even with these cost-saving techniques, the pressure on the State budget continued. On August 4, 1991, the legislature enacted tax increases amounting to approximately \$2.9 billion, allowing the State budget for FY 1991-92 to be enacted and funded.

In terms of process, the Governor has the responsibility to submit an executive budget, typically in February, for the upcoming fiscal year, which begins July 1. The budget that is developed for the Medical Assistance program represents the estimated cost of all ongoing services as well as the cost of new program initiatives and regulatory, court, and legislative changes that are anticipated to occur in the projected fiscal year. Cost savings of new initiatives and program changes are identified separately. Changes anticipated to be implemented sometime in the fiscal year are budgeted, be they cost or savings.

Following the Governor's budget submission to the legislature, hearings with department heads are then scheduled and issues involving MA are discussed between legislative members of the Appropriations Committee and the department head in both the House and the Senate. After the hearings, analysis of the program's projected need will be done by each of the four caucus staffs (Republican and Democrat) in the House and the Senate. In developing these estimates, issues important to each caucus will be incorporated, and these may differ from the Governor's budget amounts. In addition, updated data will be used to formulate the estimates and this and any new program developments such as court rulings, legislation, and economic conditions which may also cause the estimate to be adjusted. The various caucus estimates are usually compared for consistency, and any policy differences between the caucus staffs are decided by the legislative leadership of the four caucuses.

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The General Appropriations Act passed by the General Assembly for the budget year can make changes to the MA budget as submitted by the Governor. Changes may include providing fee increases, eliminating proposed cuts made by the Governor, and/or including new program initiatives that the legislature feels are worthwhile. Increases in the MA budget over and above the Governor's dollar amount often depend on the revenue available in any particular fiscal year. Should a supplemental appropriation be needed sometime during the fiscal year, the Governor will submit a request to the legislature. While the executive branch is expected to operate within the amounts appropriated, it is recognized that conditions can arise throughout the fiscal year that will significantly impact on program expenditures.

While legislative leadership does form the budget within the constraints of the total revenues estimated to be available for the upcoming fiscal year, no fixed dollar limits are established within certain program areas, that is, Medical Assistance and cash grants. With the overall revenue constraints and the rapidly proportional increase for MA program costs as a percentage of State fund expenditures, it is probable that funding has not been available to initiate or expand State programs. However, cash grants have not been reduced, nor has eligibility been restricted in either the cash grant or MA program. Cash grant increases averaging 5 percent have been provided at approximately 2-year intervals. Under this timetable, a grant increase would have become effective January 1, 1992; however, no funding for this increase was requested by the Governor, nor was the increase considered by the legislature. Therefore, it could be argued that the lack of a grant increase had more to do with the overall fiscal problems in the State than directly with the growth of the MA budget, although that growth obviously used funds that could have been used for the grant increase.

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It is anticipated that funding Medical Assistance will continue to exert pressure on the State budget at the current level. Moreover, if the Federal Government eliminates the use of voluntary contributions, the State will be faced with either significant cost increases or program cutbacks. Meanwhile, expansions of the program, as mandated by Federal law, continue to increase State fund costs. Federal mandates and court orders continue to be the cause of major program expansions in Pennsylvania and have limited the State's ability to address other problems such as access and fee structures.



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# SUMMARY OF MAJOR PROGRAM CHANGES

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## FY 1986-87 Program/Policy Changes

### Implementation Date 07/01/86

- Drug and alcohol detoxification within an inpatient setting for General Assistance recipients will be reimbursed only if the admission meets certain criteria for medical necessity.
- Responsibility for the operation of outpatient psychiatric services was transferred from the Office of Medical Assistance to the Office of Mental Health.
- Renal dialysis centers and birthing centers became eligible for reimbursement as separate provider types.
- Services provided by enrolled physicians to MA recipients in State Health Care centers will be reimbursable under the Medical Assistance Program.
- Moratorium established on capital payments for new or additional psychiatric and drug and alcohol beds.
- The Department accepted the recommendation contained in the General Appropriations Act for 1986-87 allowing Private Mental Hospitals, General Hospitals, and Rehabilitation Hospitals rates of increase of 1.95 percent over the 1985-86 fiscal year limit.

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### **Implementation Date 10/01/86**

- Phase-in of the prospective capital reimbursement system for General Hospitals over a 7-year period. Payments will consist of a hospital-specific amount and an amount added on to the prospective payment rate. After the phase-in period is completed, payment for capital costs will be made exclusively through the prospective payment rate.

### **Implementation Date 03/15/87**

- A Maximum Allowable Cost (MAX) has been established for 60 drug entities at the 70th percentile of the Estimated Acquisition Cost for each generically equivalent product listed under the generic entry in the Generic Drug Formulary.

A special State MAC has been established at 110 percent of the lowest EAC of the generically equivalent drug for any Schedule C-IV antianxiety agent classified as a benzodiazepine or a carbamate derivative.

### **Implementation Date 04/01/87**

- Short Procedure Units and Ambulatory Surgical Centers (new provider types) became eligible for reimbursement as separate provider types.

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## **FY 1987-88 Program/Policy Changes**

### **Implementation Date 07/01/87**

- On July 1, 1987, the Health Care Financing Administration approved a 3-year waiver request to provide home and community-based services to five individuals aged 21 and under.

### **Implementation Date 07/01/87**

- The Department will pay for the rental of apnea monitors prescribed for categorically needy recipients subject to the conditions and limitations described in Class III Medical Assistance Bulletin Numbers 01-87-15, 05-87-04, and 19-87-09.
- Specially enrolled medical supplies and pharmacies will be eligible to bill the Department directly for services provided on or after July 1, 1987, for the technical component of pediatric pneumograms rather than having the payment processed through the program exception process.
- Reimbursement ceilings have been established for net operating costs of general and county nursing facilities in the Metropolitan Statistical Areas (MSA) or non-MSA classification levels for services rendered from July 1, 1987, through June 30, 1988. The reimbursement ceilings established an upper limit of payment of the actual, allowable net operating costs of general and county nursing facilities. Each facility's most recent acceptable cost report that was on file with the Department by April 2, 1987, was incorporated into the data base that was used to establish the group ceilings. The net operating per diem costs of each facility were rolled forward to the common date of March 31, 1987. A 1.0-percent



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projected inflation factor was then used to roll these costs forward to June 30, 1987. A second projected inflation factor of 4.4 percent was used to roll these costs forward to June 30, 1988, the end of the period during which the ceilings will be in effect.

- The Department will pay for motorized wheelchairs prescribed for categorically needy recipients subject to the conditions and limitations described in the Class III Medical Assistance Bulletin Numbers 01-87-08, 05-87-02, and 19-87-06.

### **Implementation Date 07/29/87**

- Effective July 29, 1987, the Department will pay for a drug-free clinic visit when there is an evaluation of the physical and mental condition of the patient without an administration of medication.

### **Implementation Date 01/01/88**

- Effective January 1, 1988, a new comprehensive family-planning procedure code has been established. This code (90190), with a limit of two visits per year and a fee of \$41, includes a medical examination, routine laboratory testing, family-planning supplies, and counseling.

### **Implementation Date 01/01/88**

- The Project Independence Act established Single Point of Contact demonstrations to provide intensive case management and training opportunities to clients with barriers to employment. Successful participants who obtain jobs receive at least 4 months of extended Medical Assistance coverage. The act further provided for basic health

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care insurance coverage on a copayment basis to successful program participants who lose their Medicaid coverage owing to entering employment and who elect to take the coverage.

### **Implementation Date 01/15/88**

- The Department has issued revised State MAC prices for those drugs that were previously subject to the Federal MAC limits. The updated prices for 20 drugs became effective January 15, 1988.

### **Implementation Date 02/06/88**

- Amendments have been approved in the Pennsylvania Code enabling the Commonwealth to protect its fiscal interest in regard to the overpayment recovery rules implemented by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. These amendments establish a uniform period for the recoupment of overpayments from providers in order to fund necessary repayments to the Federal Government within the time periods established under COBRA. The amendment change relates to inpatient hospitals, intermediate care facilities for the mentally retarded, and long-term care facilities.

### **Implementation Date 03/15/88**

- German reparations payments are excluded as income and as a resource for persons in Supplemental Security Income related Medical Assistance categories for non-money payment and medically needy only.

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### **Implementation Date 04/01/88**

- Effective April 1, 1988, fees for physician office and home visits and hospital clinic and emergency room visits will be increased by \$5.
- In accordance with the Sixth Omnibus Reconciliation Act (SOBRA) of 1986, the Department is electing to create a new categorically needy Medical Assistance group composed of pregnant women and children under the age of 2 with family income up to 100 percent of the Federal poverty guidelines. This new category of recipients will become eligible April 1, 1988. Also, provisions include the phase-in of children (in 1-year intervals) until October 1, 1990, when all newly eligible children under the age of 5 will be covered.

### **Implementation Date 04/24/88**

- Reimbursement made from the Medical Assistance Program on or after April 24, 1988, for abortions is governed by certain reporting requirements specified in Act 1988-31. Abortions will be reimbursed only if (1) a physician certifies that the abortion is necessary to avert the death of the woman or (2) the woman was the victim of rape or incest and personally reported the incident to a law-enforcement agency having the requisite jurisdiction.

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## **FY 1988-89 Program/Policy Changes**

### **Implementation Date 07/01/88**

- The Department of Public Welfare announced its ceilings on net operating reimbursement for general and county nursing facilities, the Metropolitan Statistical Area (MSA), or non-MSA classification levels and related information. The reimbursement ceilings and classification levels shall be effective for services rendered from July 1, 1988, through June 30, 1989. In addition, the Department is also announcing temporary ceilings to be used for interim payments and interim rate-setting for the period April 1, 1988, through June 30, 1989, pending the promulgation of new regulations to implement a change in the State Plan establishing a new method for ceiling-setting using 115 percent of the median per diem cost. The Department will be issuing revised interim rates, as necessary, using the temporary ceilings and will be issuing instructions to providers on methods for adjusting interim payments using the revised interim rates. The temporary ceilings are not final but are for interim applications only. The Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 99-35) will probably result in increased costs to nursing facilities in the areas of nurse aide training, social workers for homes with certified beds of 120 or more, and new certification and recertification requirements. Because the cost to meet these requirements cannot be identified at this time, the Department has decided to increase ceilings to 115 percent of the median in place of ceilings calculated using the 55th percentile or 107 percent of the median, whichever is greater, in order to give facilities some flexibility in covering these anticipated costs as they are incurred.

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- As of July 1, 1988, Departmental regulations have been revised to recognize medical rehabilitation units of general hospitals as separate providers and to establish a new method to calculate rates for those units. A new method has also been established to calculate interim rates for drug and alcohol rehabilitation units and to clarify the calculation for the final audited per diem rate for private psychiatric, freestanding rehabilitation, distinct part psychiatric, and drug and alcohol detoxification/rehabilitation units of general hospitals.
  - Payments for inpatient hospital services set forth in Chapters 1151 and 1163 of the Department's regulations are being revised in the following areas: regrouping, group rates, organ transplants, rebasing relative values, readmissions, disproportionate share payments adjustment, and direct medical education payments.
  - The personal care allowance for Medical Assistance recipients has been increased effective July 1, 1988. Increased costs result from the passage of the Federal Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360), which requires that Medical Assistance recipients residing in nursing homes receive an additional \$5 per month in their personal care allowance.
  - Targeted case-management services are excluded from copayment requirements. The general function of case-management services is to assist the recipient in gaining access to needed medical, social, educational, and other services. In providing case-management services, the recipient is not necessarily required to be physically present to receive the service. Thus, the nature of the service and the manner in which it is provided make it appropriate to require copayment by the recipient.
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- Physicians who participate in the Medical Assistance Program were reminded that they must have a current license to practice medicine. In September 1987, the Pennsylvania Pharmaceutical Assistance contract for the Elderly (PACE) notified the Department that they had identified 990 physicians who had not renewed their licenses to practice medicine but are prescribing medications under the PACE Program. PACE notified the Bureau of Professional and Occupational Affairs and had also written to each physician. Upon receipt of the information obtained from PACE, the Department found that some of these PACE physicians were also prescribing drugs for Medical Assistance patients as well as rendering, ordering, or arranging for various other medical services.
  - Public announcement was made of inpatient hospitals that qualify for a disproportionate share payment adjustment to their FY 1988-89 Medical Assistance payment rates. This notice was published in accordance with section 4112 of the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub L. 97-35). States must, at least annually, publish the name of each hospital qualifying for a disproportionate share payment adjustment and the amount of such payment adjustment made for each hospital.

### **Implementation Date 08/01/88**

- Effective August 1, 1988, the Department will pay for inpatient drug and alcohol detoxification unless an alternate treatment setting is available where the appropriate treatment can be provided.



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## **Implementation Date 09/01/88**

- Amendments related to home health agency services have been adopted which modify, as of September 1, 1988, the conditions under which Medical Assistance payments will be made for services provided by home health agencies. These amendments expand the scope of coverage from 12 visits to 15 visits, adopt two levels of payment—\$30 per visit for skilled care services and \$18 per visit for home health aide services—and establish separate procedure codes in order to identify the specific caregiver.

## **Implementation Date 09/26/88**

- A clarification to conditions under which Medical Assistance recipients may be considered homebound in order to receive home health agency services was necessary. It States that a recipient is homebound if a condition due to illness or injury restricts the individual's ability to leave his residence without assistance or makes leaving medically contraindicated.

## **Implementation Date 10/01/88**

- A new Medical Assistance Program entitled "Healthy Beginnings" is being expanded which will make categorically needy Medical Assistance available to qualified children under 3 years of age with family incomes up to 100 percent of the Federal poverty guidelines. Under the Healthy Beginnings Program, there are no resource limitations.
- Amendments have been made to delete appendix A, the Medical Assistance Program Fee Schedule, from Chapter 1150 and to incorporate

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within Chapter 1150 the guidelines to be used by the Department when establishing or changing fees and when procedures, services, or items are added to, or deleted from, the fee schedule. In addition, the regulations modify current payment limitations for specific services, revise the definition of "medically necessary," replace the program exception provision contained in Chapter 1101, and add a new section relating to waivers to Chapter 1150.

### **Implementation Date 11/01/88**

- Amendments become effective as of November 1, 1988, which achieve compliance with Federal and State law by incorporating the Deficit Reduction Act of 1984 (DEFRA) (Pub. L. 98-369) changes and the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 97-35) clarifications into 55 Pa. Code. These amendments also ensure full compliance with section 403(b) of the Public Welfare Code, which mandates consistency between the General Assistance and Aid to Families with Dependent Children regulation and standards to the extent possible under State law. These amendments incorporate clarification of resource and income provisions issued by the Department during recent years and will facilitate accurate application of resource and income requirements, thereby reducing errors. These amendments also remove the procedural matter from the resource and income chapters and restructure the requirements more logically. The regulations update and consolidate the resource requirements for the Medical Assistance (MA) Program into a new Chapter 178. Chapter 178 contains the resource requirements that persons must meet to be eligible for coverage under MA. The amendments also update and consolidate the income requirements of the MA Program into a new Chapter 181. Chapter 181

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contains the income requirements that persons must meet to be eligible for MA benefits.

- The Department of Public Welfare announces an increase in Medical Assistance fees for independent medical clinic visits, home health agency visits, and partial psychiatric hospitalization visits. The revised reimbursement levels are effective for services provided on and after November 1, 1988. The independent medical clinic visit is increased from \$15 to \$23; home health agency visit fees for nurses, physical therapists, occupational therapists, and speech therapists are increased from \$30 to \$41; the home health agency visit fee for home health aides is increased from \$18 to \$22; and the psychiatric partial hospitalization visit procedure codes W0860, W0861, and W0864 are increased from \$5.50 to \$6, and procedure code W0865 is increased from \$6.50 to \$7.

### **Implementation Date 12/01/88**

- Through consultation with representatives of the American Academy of Pediatrics (AAP) and as a result of their recommendations, the Department has decided to increase the number of compensable Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations from 16 to 20 to be consistent with the AAP "Recommendations for Preventive Pediatric Health Care." Effective December 1, 1988, recipients are eligible for a total of 20 EPSDT screens from birth through 20 years of age. The first 16 screens will be paid at the standard EPSDT rate. If a child receives all 20 screens, the last 4 (17, 18, 19, and 20) will be paid at the Medical Assistance office or clinic visit rate.

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## Implementation Date 01/01/89

- In 1987, Congress enacted major nursing home reform legislation affecting providers participating in the Medicare and Medical Assistance Programs as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 97-35). Congress made some technical amendments to OBRA in Title IV, Subtitle B, of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360, 102 Stat. 768) (July 1, 1988). The nursing home reform provisions enacted by Congress established a timetable for action by Federal and State agencies as well as by providers from 1987 through 1993, including requirements for continuing approval of State Plans. In a number of cases, State agencies are required to take action even where Federal guidelines required by the law are not timely promulgated. The reform provisions grew out of concerns that the preexisting system of certification and review of participating providers did not adequately deal with the quality of patient care and did not sufficiently inform patients and providers of rights and limitations. While most of the new requirements established by OBRA do not become effective until October 1, 1990, some are required to be implemented prior to that date. Since the enactment of OBRA, the Department in cooperation with the Departments of Aging, Education, Health, and State and the Governor's Budget Office and Office of Policy as well as with the responsible Federal agencies and representatives of providers and recipients has been conducting planning and development activities necessary for the implementation of OBRA. These activities are part of a program of change to improve the quality of care provided in nursing facilities, to provide quality services in the most appropriate setting, and to increase public awareness of rights and limitations under the Medical Assistance Program. The Department is the single State agency for the administration of the Medical Assistance Program in this

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Commonwealth and is therefore responsible for issuing information and regulations with respect to the application of OBRA to the Medical Assistance Program. OBRA requires the Department to implement certain provisions of the law on January 1, 1989. These provisions are:

- specification of nurse aide training and competency evaluation programs and those competency evaluation programs that the Department approves for use by providers and that meet requirements established by the law;
- establishment of a registry of individuals who satisfactorily complete a nurse aide training and competency evaluation program approved by the Department;
- implementation of a preadmission screening program, applicable to persons seeking admission to a provider nursing facility, whether or not that person is applying for or receiving Medical Assistance, to determine, based on criteria established by the Federal Government under OBRA, whether persons who are mentally ill or mentally retarded or have related disabilities require nursing facility services and, if they do, whether they also require active treatment for their conditions;
- implementation of an appeals process for individuals who are adversely affected by the preadmission screening program and wish to seek relief; and
- enforcement of conditions of participation established by OBRA effective for current nursing facility providers.



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- The Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA) (Pub. L. 99-509) provides the option for the creation of a new categorically needy group of elderly/disabled individuals with family incomes up to 100 percent of the Federal Poverty Guidelines. Federal law also permits participation in Medicare cost-sharing for this group. The resource standard for this new categorically needy program is the Supplemental Security Income (SSI) resource standard. The Department has elected to implement the SOBRA provisions effective January 1, 1989, by providing categorically needy Medical Assistance coverage under the Healthy Horizons Program to elderly/disabled individuals with family incomes up to 100 percent of the Federal Poverty Guidelines and resources not exceeding the SSI resource standards. The Department will also participate in Medicare cost-sharing and for all Qualified Medicare Beneficiaries in this new group. The Department is also implementing the Healthy Horizons Cost-Sharing Program for those Qualified Medicare Beneficiaries who are eligible for Medicare cost-sharing only under the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) provisions. These will be Qualified Medicare Beneficiaries with incomes up to 100 percent of the Federal Poverty Guidelines and resources in excess of the SSI resource standards but not exceeding twice the SSI resource standards. However, Qualified Medicare Beneficiaries with incomes within 100 percent of the Federal Poverty Guidelines and resources within the SSI resource standards may elect to participate in Medicare cost-sharing only.
  - Regulations at 55 Pa. Code 178.1(a)(1) establish that the resource limits for the Categorically Needy Nonmoney Payment Medical Assistance Program for aged, blind, and disabled persons are equivalent to the Supplemental Security Income (SSI) resource limits at 20 CFR 416.1205. Effective January 1, 1989, the SSI limits will increase in accordance with
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provision of the Deficit Reduction Act of 1984 (DEFRA) (Pub. L. 98-369).

- Beginning on January 1, 1989, the Medical Assistance Program will cover hospice care for terminally ill categorically and medically needy recipients who elect to receive hospice care from hospices that are Medicare certified and enrolled in the Medical Assistance Program. As required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272), the Medical Assistance hospice benefit will coincide with the Medicare hospice benefit with only those exceptions permitted by COBRA. Therefore, the Medical Assistance Program will require compliance with the Medicare regulations at 42 CFR Part 418—Hospice Care with certain exceptions.
- Providers were notified that effective with the filing of the next audit conducted by the Office of Medical Assistance Programs, disallowances related to the funded depreciation requirements will not be taken.
- The Department issued an updated list of agencies that will conduct Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 97-35) evaluations and terminology to be used with each type of agency by the type of assessment they perform.

### **Implementation Date 02/06/89**

- A statement of policy was issued by the Department concerning the establishment of a uniform period for the recoupment of overpayments from providers in order to fund necessary repayments to the Federal Government within the time periods established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272).

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This statement of policy is applicable to long-term care facilities enrolled in the Medical Assistance Program.

### **Implementation Date 03/01/89**

- A Second Opinion Program (SOP) for certain surgical procedures provided to Medical Assistance recipients was implemented. The Department will review elective admissions before they occur through the Place of Service Review (PSR) Program and, under certain circumstances, require recipients to secure a second opinion as to possible treatment alternatives through the SOP. Through the SOP, the Department anticipates an increase in patient awareness of both surgical and nonsurgical treatment options. The increased awareness of treatment necessity and treatment option should result in a reduction of unnecessary services and the costs and risks associated with them.

### **Implementation Date 06/30/89**

- The Department, through an amendment to regulations set forth in Annex A, proposes to implement a disproportionate share allowance payable to general nongovernmental long-term care facilities. Act 55A (the first Supplemental Appropriation Act to the General Appropriation Act of 1988) provided for a one-time, long-term care disproportionate share allowance payable according to a formula established by the Department. This disproportionate share payment allowance is intended as an added benefit to long-term care facilities in which Medicaid-funded patient days accounted for at least 90 percent of the total patient days. Payment is contingent upon Federal approval of the Department's proposed change to the regulations.

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## **FY 1989-90 Program/Policy Changes**

### **Implementation Date 07/01/89**

- The Department announced that the percentage limitation for FY 1989-90 for hospitals and units reimbursed under principles of cost reimbursement will be established at 2.5 percent. The 2.5-percent limit on annual rates of increase in per diem rates applies to freestanding private psychiatric, and rehabilitation hospitals, distinct part psychiatric, and drug and alcohol detoxification/rehabilitation and medical rehabilitation units. The Department also announced that the group rates for FY 1989-90 will be increased by 2.5 percent over the FY 1988-89 group rates. The increase in group rates applies to inpatient hospitals reimbursed under the prospective payment system. The estimated increase in expenditures resulting from these changes is expected to be \$11.502 million (\$6.787 million in State funds).
- Effective July 1, 1989, all pharmacies and dispensing physicians may once again submit claims to the Department for Imodium A-D (loperamide HC1) liquid prescribed for and dispensed to any medical assistance recipient eligible for prescription benefits through the Medical Assistance Program. The Department will reimburse these claims in accordance with its regulations.
- The Department issued a notice announcing its ceilings on net operating reimbursement for general and county nursing facilities, the Metropolitan Statistical Area (MSA) or non-MSA classification levels, and related information. The reimbursement ceilings established an upper limit of payment of the actual, allowable net operating costs of general and county nursing facilities. Each facility's most recent acceptable cost

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report that was on file with the Department by April 3, 1989, was incorporated into the data base that was used to establish the group ceilings.

### **Implementation Date 08/01/89**

- Effective August 1, 1989, the fee for Volunteer Ambulance Service Company (VASC) certified emergency (pre-hospital) transportation service was increased from \$30 to \$60 and the fee for non-VASC certified emergency (pre-hospital) transportation service was increased from \$20 to \$50.
- Effective August 1, 1989, Advanced Life Support (ALS) and Specialized Services (critical care, with transport, interfacility cases of neonatal, prenatal, or cardiac service) were added as covered services for ambulance companies enrolled in the Medical Assistance Program.
- The Department issued a notice regarding fee increases for family-planning clinic revisit and podiatrist office and home visit. Fees for family-planning clinic revisits (medical followup) increased from \$15 to \$23, with a limit of two visits per year. The fee for the podiatrist office visit increased from \$9.50 to \$18 and the fee for podiatrist home visit increased from \$9.50 to \$19.

### **Implementation Date 10/01/89**

- The Department issued a statement of policy to provide information on the implementation of the appeals process required by the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 99-35) with respect to transfers and discharges from nursing facilities participating in the

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Medical Assistance Program. The statement of policy affects recipients in the Medical Assistance Program who are now, or who will be, receiving services in skilled-care facilities and intermediate-care facilities (but not intermediate-care facilities for the mentally retarded) which participate as providers in the Medical Assistance Program as well as those providers of services.

- A statement of policy was issued to advise of certain changes in Medical Assistance (MA) requirements and procedures to implement the Spousal Impoverishment Provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA) (Pub. L. 100-360, Section 303[a]). MCCA provides for special financial relief for married couples who live together and are faced with high medical bills as a result of one of them being admitted to a nursing home or other medical institution for skilled nursing care, heavy care/intermediate services, or intermediate care, including intermediate-care facilities for the mentally retarded. MCCA significantly relieves the financial burdens for these couples by requiring, within specific guidelines and financial limits, the protection of income and resources for the spouse in the community. This is accomplished by permitting the institutionalized spouse who is eligible for MA to give some of his income and resources to the community spouse up to specified limits without affecting his eligibility for MA.
- The Department issued a statement of policy which provides information on the implementation of sanctions required by the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 99-35) with respect to compliance with statutory requirements for nursing facilities established by the act. The statement of policy affects skilled nursing facilities and intermediate-care facilities (but not intermediate-care facilities for the



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mentally retarded) participating as providers or seeking to enroll as providers in the Pennsylvania Medical Assistance Program.

- Effective with admissions on or after October 1, 1989, the Department will reject claims grouping into Diagnostic Related Groups (DRGs) 385-391 for recipients age 1 or older upon admission. The claims will have to be submitted with an age-appropriate principal ICD-9-CM code in accordance with normal MA billing procedures. These claims will no longer be eligible for cost outlier payments but will be eligible for day outlier payments if appropriate.
- Effective October 1, 1989, the fee for Volunteer Ambulance Service Company (VASC) certified nonemergency transportation service was increased from \$30 to \$60, and the fee for non-VASC certified nonemergency transportation service was increased from \$20 to \$50.
- The Department issued a statement of policy to implement changes to the Medical Assistance income regulations as a result of changes to certain income requirements mandated by the Family Support Act of 1988 (FSA) (Pub. L. 100-485) for the Aid to Families with Dependent Children (AFDC) Program. The provisions affecting the calculation of income are as follows: (1) Earned Income Tax Credit (EITC) disregarded; (2) standard deduction increased from \$75 to \$90 for AFDC-NMP; (3) increase in maximum monthly child-care deduction to \$175 per child and to \$200 for children under age 2; (4) increase in minimum work expense deduction from \$75 to \$90 for AFDC-MNO; (5) increase in work expense deduction from a legally responsible relative from \$75 to \$90; and (6) sequence of deductions from earned income is revised so that the \$30 plus 1/3 incentive deduction is applied before child-care deduction.



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## **Implementation Date 12/29/89**

- A statement of policy was issued which provides county and general nursing facilities enrolled in the Medical Assistance Program with information on how Initial Resident Reviews (IRRs) required by the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 99-35) will be conducted by the Office of Medical Assistance Programs. The purpose of the IRR is to ensure that a person (Medical Assistance recipient or private pay) who needs active treatment for mental illness, mental retardation, or another related condition is identified and appropriate services are offered to that individual. To meet the requirement of the OBRA IRR, each nursing facility must complete a PA-PASARR-ID (Preadmission Questionnaire for Applicants to Nursing Facilities in Pennsylvania) form on all affected individuals. If an individual requiring further assessment is identified, a Facility Report Form must also be completed.

## **Implementation Date 01/01/90**

- The Department announced an increase in the total compensable hours of psychotherapy per patient per 30-day period provided by enrolled drug and alcohol clinics from 6 to 8 hours. This includes individual, family, and group psychotherapy. A fee increase for psychotherapy visits at drug and alcohol clinics from \$12.50 to \$15 per half hour was also effective January 1, 1990.
- The income limits for the Categorically Needy Nonmoney Payment (NMP) Medical Assistance Program for aged, blind, and disabled persons increased due to the Federal cost-of-living increase. The income limits

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are based on the Federal benefit rate payable under Title XVI of the Social Security Act.

### **Implementation Date 04/01/90**

- The Department announced that selected laboratory procedures will be replaced with more specifically defined procedures. No fiscal impact is expected from this change.
- A statement of policy was issued by the Department regarding implementation of the new Extended Medical Coverage (EMC) under the Categorically Needy program. The Family Support Act of 1988 (Pub. L. 100-485) requires that States provide EMC benefits for up to 12 months to families ineligible for AFDC/AFDC-U cash assistance due to earned income or loss of income incentives. The intent of the EMC provision is to help families retain employment, increase independence, and reduce the likelihood of returning to cash assistance.
- The Department announced the implementation of the Healthy Beginnings Plus Program, which significantly expands the scope of maternity care benefits with an emphasis on comprehensive and coordination services. The program is designed to maximize benefits to reduce infant mortality and critical illness in infancy resulting from manifestations of poverty such as poor nutrition, drug and alcohol addiction, poor prenatal care, etc. In addition to the comprehensive services and increased fees, extensive guidelines have been established for the provision of these services. In order to participate in the program and receive medical assistance payments, an eligible provider must formally enroll in the Healthy Beginnings Plus Program and meet specific requirements established by the Department.

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### **Implementation Date 04/07/90**

- Amendments to Chapter 1147, Optometrist's Services, were adopted by the Department. These amendments permit optometrists to (1) arrange their professional practice to include service to a licensed health care facility; (2) as a professional courtesy, attend the patients of another optometrist in the office of the other optometrist during a temporary absence from practice if consistent with other duties; and (3) provide services to a patient who is physically incapable of coming to the optometrist's office at the patient's residence or location. Additionally, the definition of a vision examination has been modified to reflect the State Board of Optometry definition.

### **Implementation Date 04/21/90**

- A statement of policy was published to issue guidelines and clarify policy related to payment for medical-surgical and psychiatric consultations for physicians enrolled in the Medical Assistance Program.

### **Implementation Date 05/26/90**

- A statement of policy was issued to provide immunization guidelines for use in serving recipients during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations.

### **Implementation Date 06/08/90**

- The Department issued a statement of policy regarding the use of Medicare Form HCFA-485 by home health agencies as verification of the physician's prescription for medical/surgical supplies. The requirement

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that medical/surgical supplies must be ordered on a physician's prescription pad has not changed.

### **Implementation Date 06/30/90**

- Public announcement was made of inpatient hospitals that qualify for a disproportionate share payment adjustment to their FY 1989-90 Medical Assistance payment rates in accordance with section 4112 of the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 97-35). OBRA was amended in the Medicare Catastrophic Coverage Act of 1988 (MCCA) (Pub. L. 100-360) to provide that States must, at least annually, publish the name of each hospital qualifying for a disproportionate share payment adjustment and the amount of such payment adjustment made for each hospital.

## **FY 1990-91 Program/Policy Changes**

### **Implementation Date 07/01/90**

- A notice was published to announce a proposed revision of 55 Pa. Code, Chapter 1121, as to the payment system for multisource drugs. Under the proposed change, the Department will not make payments for multisource drugs higher than the cost limits established for each such drug by the Federal Government under 42 CFR Part 447.332. Formal rules implementing this change are currently being reviewed under the Regulatory Review Act of 1989. If rules are not adopted by the Department, the present payment system for multisource drugs will continue. The changes are being adopted under the Department's

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authority to take measures necessary to avoid loss of Federal funds and are required for that purpose.

- The Department announced its intent to reimburse Certified Registered Nurse Practitioners (CRNP) for services provided to categorically and medically needy recipients in accordance with requirements set forth by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), P.L. 101-239, Section 6505.
- The Department issued a notice announcing its ceilings on net operating reimbursement for general and county nursing facilities, the Metropolitan Statistical Area (MSA) or non-MSA classification levels, and related information. The reimbursement ceilings established an upper limit of payment of the actual, allowable net operating costs of general and county nursing facilities. Each facility's most recent acceptable cost report that was on file with the Department by April 2, 1990, was incorporated into the data base that was used to establish the group ceilings.
- A statement of policy was published to notify all skilled nursing facilities of the dual participation requirement for the Medicare and Medical Assistance Programs. Dual participation is a necessity in order to access Medicare resources for patients who are eligible for Medicare benefits. In the past, when the entire facility was not enrolled in the Medicare Program, the Department had to assume responsibility for patient care costs, even though Medicare eligibility existed. Facilities providing skilled care, enrolled in the Medical Assistance Program with more than 60 licensed beds, shall also be enrolled in the Medicare Program to the extent that they have sufficient beds to accommodate their Medicare-eligible residents. This does not preclude those facilities with a bed



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complement of under 60 beds from enrolling in the Medicare Program. Any facility certified to participate in the Medicare Program must have sufficient beds to accommodate its Medicare-eligible residents. Payment will be based on criteria as found in Chapter 1181, Section 1181.51(b).

- The Department announced that the FY 1990-91 annual rate of increase in per diem rates for private psychiatric and rehabilitation hospitals and distinct part psychiatric, drug and alcohol detoxification and rehabilitation, and medical rehabilitation units of general hospitals will be established at 5.3 percent. The estimated increase in expenditures resulting from the 5.3-percent factor is expected to be \$4.199 million (\$2.866 million in State funds) for FY 1990-91.
- The Department of Public Welfare, under the provisions of the General Appropriations Act of 1990, Act 7-A, gave notice of its intent to revise the policy governing payments to hospitals for direct medical education. Under the proposal, not earlier than July 1, 1990, medical education payments would be made to eligible hospitals only as necessary to assure that the total amount of payments made to each hospital under its base inpatient rate from July 1, 1990, to June 30, 1991, is equal to the total amount of payments to each hospital under its base inpatient rate from July 1, 1989, to June 30, 1990, plus an inflation factor of 7 percent, and the State portion, of its medical education payments for FY 1989-90.

### **Implementation Date 07/14/90**

- Proposed rulemaking was published to amend 55 Pa. Code, Chapter 1101, to add section 1101.44, Waiver of Concurrent Claims. As a condition of participation, a provider waives the right to seek a claim against the Commonwealth for covered services provided to Medical



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Assistance recipients before the Board of Claims. Under the proposed regulation, all disputes concerning payment for services rendered by a provider to a recipient must be brought originally before the Department's Office of Hearings and Appeals. This waiver is a condition of a provider's continued participation in the Medical Assistance Program. The regulation does not otherwise change or limit providers' rights to seek relief authorized by law before the Commonwealth Court of Pennsylvania or any other court.

### **Implementation Date 08/04/90**

- Proposed rulemaking was published to amend 55 Pa. Code, Sections 1101.68 and 1163.451, relating to invoicing for services payment for cost-reimbursed hospital services. The purpose of these proposed amendments is to update the Department's policy regarding invoicing for services by providers enrolled in the Medical Assistance Program. These amendments are being proposed to ensure consistency among providers regarding the Department's invoicing policy. Additionally, these proposed amendments will increase the Department's ability to provide reimbursement to providers in a more efficient and consistent manner.

### **Implementation Date 10/01/90**

- The Department announced plans to require prior authorization for incontinence items prescribed for persons 3 years of age and older. This requirement will show medical necessity exists before payment is made for an item.

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## **Implementation Date 01/01/91**

- The Department adopted amendments to update its policy regarding invoicing for services by providers enrolled in the Medical Assistance Program. These amendments are being adopted to ensure consistency and to alleviate uncertainty among providers regarding the Department's invoicing policy. Additionally, these amendments will increase the Department's ability to provide reimbursement to providers in a more efficient and consistent manner.
- A notice was published to announce an increase in the Medical Assistance Spousal Impoverishment standards for both income and resources based on the Consumer Price Index (CPI). The revisions are required under the Spousal Impoverishment Provision of the Medicare Catastrophic Coverage Act of 1988 (MCCA), P.L. 100-360, Section 303(a).

## **Implementation Date 01/05/91**

- The Department announced the implementation of changes to the transfer of resources for fair consideration requirements for the Categorically Needy Nonmoney Payment (NMP) and Medically Needy Only (NMO) Medical Assistance Programs. These changes are mandated by the Medicare Catastrophic Coverage Act of 1988 (MCCA), P.L. 100-360, Section 303(b), enacted July 1, 1988, as amended by the Family Support Act (FSA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). The change in the requirements as mandated by MCCA and amended by the FSA and OBRA provides that the transfer of resource rule no longer applies to persons who are not institutionalized.

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### **Implementation Date 01/11/91**

- The Department adopted amendments to 55 Pa. Code 1121 to implement a payment system for multisource drugs which meets current regulations established by the Federal Government pertaining to payment by State Medicaid agencies for multisource drugs. Failure to come into compliance with the Federal upper limits will result in the loss of Federal funds. The Department proposes to accomplish this by revising the method for determining payment levels for multisource drugs under the State Maximum Allowable Cost (MAC) program.

### **Implementation Date 01/18/91**

- A statement of policy was published to provide revised immunization guidelines for use in serving recipients during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations.

### **Implementation Date 03/01/91**

- Amendments to Chapters 181 and 1163 of 55 Pa. Code were published as emergency regulations to offset expanding costs to the Commonwealth of providing basic Medical Assistance and to bring the Commonwealth into compliance with Federal requirements. The amendments include the following:
  - The amount of reimbursement for inpatient hospitals enrolled in the Medical Assistance Program for hospital outlier payments is reduced from 100 percent of reported costs to 80 percent.

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- The veterans aid and attendance and housebound allowance portion of the Veterans Administration pension is counted as available income when determining payment toward costs of care of an institutionalized person. This allowance will also be counted as income when determining the available income of the institutionalized spouse for maintenance of the spouse in the community and maintenance of a child, parent, or sibling who is a dependent and living at home with the community spouse.
  - The amount of Medical Assistance expenses which can be used as deduction from income in determining initial and ongoing eligibility of Medical Assistance will be limited to 75 percent of the actual cost of medical expenses paid and unpaid in the month of application or any retroactive month for which Medical Assistance is requested.

### **Implementation Date 04/01/91**

- A statement of policy was issued by the Department to add new categories of procedures which require a mandatory second opinion when an urgent or emergency situation does not exist. The new categories of procedures are submucous resection, bunionectomy, carotid endarterectomy, and hip replacement. The statement of policy applies to acute care hospitals, short procedure units, free-standing ambulatory surgical centers, clinics, physicians, dentists, and podiatrists enrolled in the Medical Assistance Program.

### **Implementation Date 05/01/91**

- Emergency regulations were adopted to increase the copayment amount required for pharmacy services, drugs, and over-the-counter medications

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from \$0.50 per prescription and \$0.50 per refill to \$1 per prescription and \$1 per refill.

### **Implementation Date 06/29/91**

- Public announcement was made of inpatient hospitals that qualify for a disproportionate share payment adjustment to their respective FY 1990-91 Medical Assistance inpatient hospital payment rates or for a lump-sum disproportionate share payment in accordance with section 4112 of the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 93-35). OBRA was amended in the Medicare Catastrophic Coverage Act of 1988 (MCCA) (Pub. L. 100-360) to provide that States must, at least annually, publish the name of each hospital qualifying for a disproportionate share payment or payment adjustment and the amount of such payment or payment adjustment made to each hospital.

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# **Medicaid Expansions in Texas: Program Growth and Innovative Financing**

Diane Stewart

Center for Public Policy Priorities  
Benedictine Resource Center

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## The Economic and Political Context

On May 11, 1986, a headline in Texas' capital city newspaper, the *Austin American Statesman*, proclaimed "Texas at the Turning Point." The collection of articles subsumed under this banner headline dealt with the impact of the fall in oil prices and the devaluation of the peso on the Texas economy and the implications for State government. While elsewhere in the country States were experiencing their own versions of the "Massachusetts Miracle," Texas was coming to terms with its first persistent economic downturn in four decades. In the 5 years prior to 1983, Texas' own-source revenue growth had averaged 12.7 percent annually.<sup>100</sup> By 1987, tax collections from measures in effect in 1983 had declined by 8 percent.<sup>101</sup> Between late 1983 and the end of 1986, economic conditions had forced State lawmakers to enact measures to raise close to \$7 billion in revenues to cover impending shortfalls and had spurred the Governor to ask State agencies to reduce their budgets by 13 percent.

During the spring of 1986, Federal policymakers were also at a turning point. Members of Congress, Federal and State officials, and human services advocates were debating the merits of "decoupling" Medicaid eligibility from participation in Federal financial assistance programs. Historically, Medicaid participation was linked to eligibility for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). The changes being contemplated would create options for States to expand Medicaid eligibility to pregnant women and young children who, though poor, still had incomes higher than the AFDC income eligibility guidelines. Later that year,

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<sup>100</sup>Fiscal Size Up: 1984-85 Biennium Texas State Services, Texas Legislative Budget Board, December 1983, p.10.

<sup>101</sup>Fiscal Size Up: 1988-89 Biennium Texas State Services, Texas Legislative Budget Board, December 1987, p. 13.

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Congress would enact the first option to "decouple" medical and financial assistance.

Both of these developments in 1986 set the stage for significant changes in Texas' and the Federal Government's perspectives on financing health care for the poor. Once the precedent was set for increasing Medicaid income limits above State-set eligibility guidelines for AFDC, mandated eligibility expansions were not far behind. Whereas Congress had never found the political will to set Federal eligibility and grant levels for AFDC, it seemed easier to justify requiring States to offer Medicaid to poor mothers and children who did not qualify for AFDC. Furthermore, faced with a persistent deficit and a pent-up desire to legislate, Congress would use Medicaid mandates as a way to implement popular new programs at half the cost to the Federal Government.

Over the next few years, Texas' views about Medicaid would also be substantially altered. State officials would increasingly come to view Medicaid as a method of finance for many State services—not simply as a jointly funded health care program. Coupled with an emerging desire to offer improved prevention-based health care services, particularly for children, the recognition of Medicaid as a source of Federal funds would spur officials to exert Medicaid expansion options.

Even as Congress began enacting Medicaid mandates, Texas' initial response to the Federal imposition of program expansions was—perhaps surprisingly—benign and restrained. Three major factors contributed to this restraint. First, the political context during that period of time was conducive to the improvement of health care services. A highly influential Task Force on Indigent Health Care had instigated several proposals for improving health services in the State, greatly heightening awareness of the problem among

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lawmakers. Further, until January 1991, William P. Hobby was Lieutenant Governor, the most powerful elected statewide official in Texas Government given the constitutional weakness of the Governor's office. Hobby, whose mother had been the first Secretary of the Federal Department of Health, Education, and Welfare, was very sympathetic to the idea of expanding health care services in Texas. Finally, the chairman of the board of the Texas Department of Human Services, the State's Medicaid agency, J. Livingston Kosberg, was an influential businessman, Democratic fundraiser and political ally of Hobby's who was determined to improve Texas' health and human services and who saw Federal mandates as a secure foundation upon which further Medicaid improvements could be based.

Political considerations also made Texans cautious about criticizing the mandates, since many of the new legislative requirements were initiated by two powerful members of the Texas congressional delegation: U.S. Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, and Congressman Mickey Leland, a senior and influential member of the House subcommittee with jurisdiction over Medicaid.

Second, Texas' Federal matching percentage was climbing, softening the blow of mandates and bringing in relatively "cheap" Federal dollars. Federal matching rates—the proportion of States' Medicaid costs the Federal Government will pay—are supposed to be sensitive to a State's economic condition, reflecting both the increased caseloads and the diminished ability to absorb cost increases that result from economic troubles. A State with high incomes paid up to a maximum of 50 percent of its Medicaid program costs, while the poorest State paid only 25 percent of its costs.

Until FY 1987, matching rates were recalculated every other year by use of per capita income data as a proxy measure of economic conditions in a State.

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A Federal law change effective in October 1986 required that matching rates be recalculated annually, making them more sensitive to economic conditions and causing Texas' share of Medicaid costs to begin declining. As shown in figure 1, Texas paid almost 46 percent of its Medicaid costs in 1986. With the changes in the Federal calculation schedule and a large drop in the State's per capita income, the State's share of Medicaid expenditures steadily declined until, by 1991, Texas was paying only about 36 percent of the program's costs.

Finally, bridle as they might under dictates from the Federal Government, many State officials recognized that Texas' history of meager support for health and human services, even in the best of economic times, made self-initiated improvements in Medicaid difficult to sustain. Those who advocated health and human services funding initially saw Medicaid mandates as securing permanent access to services for certain groups, thereby relieving them of the necessity of defending those services through every round of budget negotiations.

## **Cost Increases in the Texas Medicaid Program**

The growth in the annual State and Federal costs of the Texas Medicaid program in the last 5 years has been substantial. As depicted in figure 2, State and Federal expenditures for the Texas Medicaid program have risen from \$1.7 billion in FY 1986 to \$4.3 billion in 1991, an increase of more than 150 percent. Whereas Texas' share rose from \$763 million to \$1.6 billion during this period, an increase of 106 percent, Federal expenditures rose from \$908 million to \$2.7 billion, an increase of 200 percent. The slower rate of growth in State costs during this 5-year period was attributable to increasingly favorable Federal match rates.



# Texas Medicaid Match Rates 1982 - 1992 (Projected)

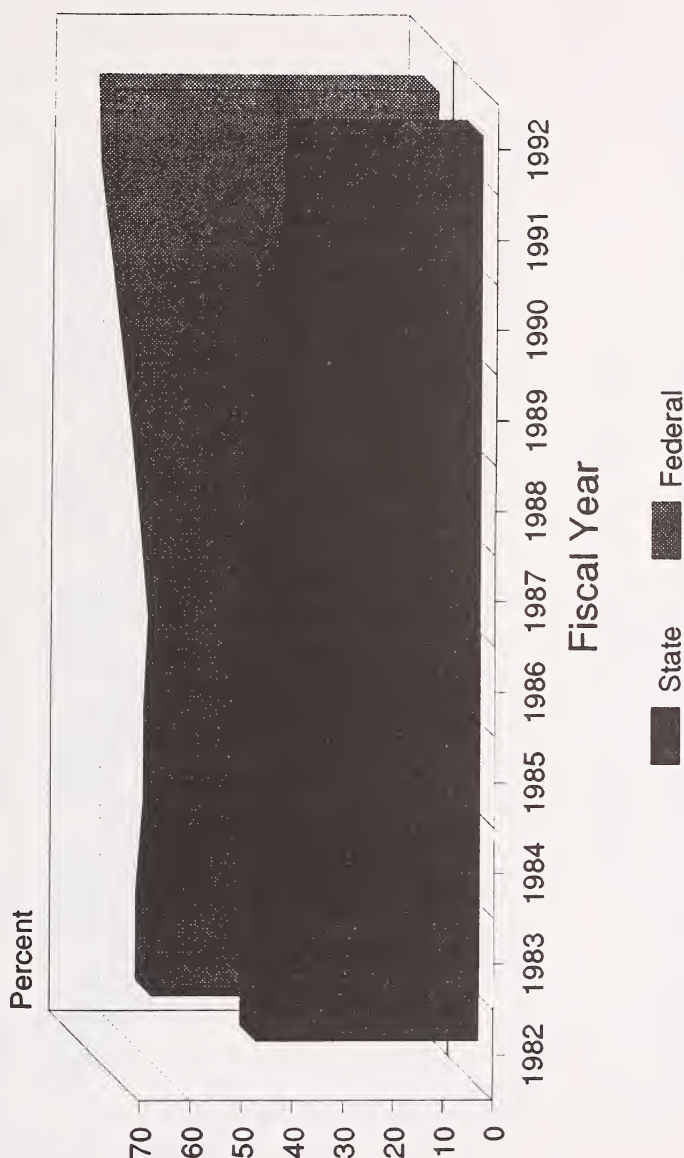


Figure 1



# Texas Medicaid Expenditures 1986 - 1992 (Projected)

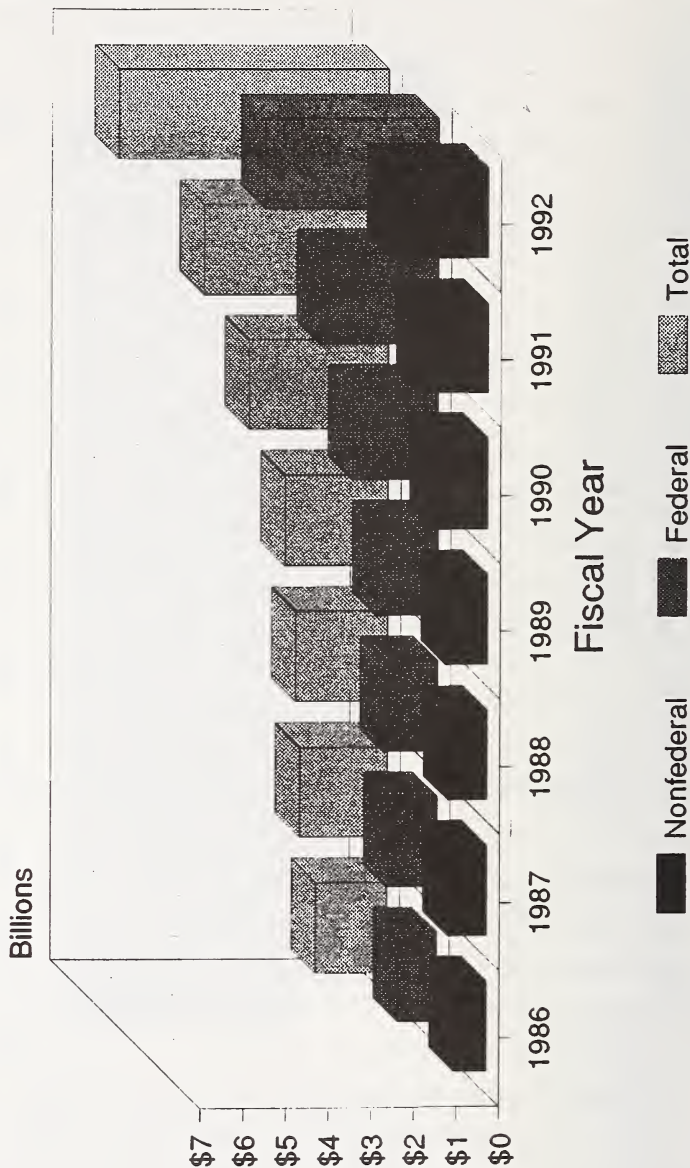


Figure 2

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Medicaid has also increased proportionately as a share of the total State budget and as a percentage of Texas' health and human services spending. Between 1986 and 1991, the State's total annual budget increased 54 percent, from \$17.7 billion to \$27.2 billion, while non-Medicaid spending increased 43 percent, from \$16 billion to 22.9 billion. The Medicaid program represented 9.4 percent of the State budget in FY 1986. By 1991, it had reached 16 percent. In 1992, Medicaid expenditures are expected to comprise 22 percent of the State budget. Medicaid expenditures in 1986 were 44 percent of the State's spending on health and human services programs. By 1991, Medicaid costs made up 58 percent of the Texas health and human services budget.

### **Medicaid Growth Between FY 1986 and FY 1988**

Medicaid cost increases during FY 1986 and FY 1987 were primarily attributable to two factors: the increased need for services that resulted from Texas' sustained economic problems and the ongoing implementation of program changes initiated in FY 1985. These cost increases in Texas' program were offset somewhat by a reduction in Medicaid provider reimbursement rates. The net increase in Medicaid spending in FY 1987 from FY 1986 was \$383 million, or 23 percent, and FY 1988 Medicaid costs, minus the reimbursement rate reduction, rose \$98.2 million, a 5-percent increase over FY 1987.

The number of AFDC recipients who were categorically eligible for Medicaid grew 14 percent annually during FY 1985 and 1986,<sup>102</sup> reflecting three factors: an increase in AFDC standard of need, allowing increased

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<sup>102</sup>Fiscal Size Up: 1990-91 Biennium Texas State Services, Texas Legislative Budget Board, December 1989, p. 5-11.

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access in 1985; a growing number of people in poverty; and a younger-than-average population. Caseloads of other categorically eligible Medicaid recipients, such as the aged and persons with disabilities, remained relatively stable when compared with AFDC-related Medicaid recipients.

Caseload increases during FY 1986 and 1987 also showed the effects of previous Medicaid expansions. In FY 1985, the Texas Department of Human Services implemented several Medicaid expansions. Some of these were State-initiated, while others were federally mandated as part of the Deficit Reduction Act of 1984.

During the summer of 1984, after Congress passed its first round of Medicaid mandates under the Deficit Reduction Act (DEFRA), J. Livingston Kosberg, chairman of the board of the Texas Department of Human Services, instructed agency staff to go beyond the new Federal requirements. By resolution and a rider to the State budget, the Texas legislature had expressed its intent that the agency expand Medicaid coverage to more children and pregnant women. This authority to expand services was contingent upon the defeat of Reagan administration proposals to cap each State's Federal Medicaid funds, since otherwise, Texas' effective matching rate would have decreased significantly.

Using the agency's authority to make changes in its Medicaid program without statutory approval, the board chairman asked for an implementation plan that would offer Medicaid beyond those mandated by DEFRA services to additional groups of needy pregnant women and children. In response to this assignment, the agency began offering Medicaid services to five new groups during FY 1985:

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- Children up to age 19 (Federal law mandated coverage of children up to age 5) whose families meet AFDC income and resource eligibility requirements but who have two parents, making them otherwise ineligible;
  - Any pregnant women whose income would qualify them for AFDC-related coverage but who are not eligible for AFDC (Federal law more narrowly defined which pregnant women were required to be covered);
  - Newborn children whose mothers were eligible for Medicaid at the time of their birth (this item was a Federal mandate);
  - Families who lost eligibility owing to the elimination of the earned income disregard for 15 months after denial (Federal law required 9 months); and
  - Medically needy families with children whose income is up to one-third higher than that allowed for AFDC participation (State opinion).

The combined effects on the Medicaid caseload of these expansions and the precipitous economic downturn were beginning to be fully felt by the end of FY 1986. Caseload growth largely accounted for an increase of \$426 million in Medicaid costs between FY 1986 and FY 1987. Between FY 1987 and FY 1988, however, caseload growth had slowed, resulting in an increase of only \$152 million.

The net cost increases in Texas' Medicaid program during these two fiscal years were somewhat less than they would have been because of cost-cutting



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and the first annual increases in the State's Federal matching rate. In July of 1986, Texas implemented the only significant spending cut that was to occur over the next 5 years, prompted not by Medicaid cost increases but by the severe State revenue shortfall that had been produced by a sluggish economy. Governor Mark White had asked State agencies to reduce their budgets for the 1986-87 biennium by 13 percent. In response, the Department of Human Services reduced selected Medicaid provider reimbursement rates by 10 percent. This measure reduced provider payments in FY 1987 and FY 1988 by \$43 million and \$54 million, respectively.

State costs for Texas' Medicaid program were further offset in these 2 years by the increase in Texas' Federal matching rate. During FY 1986, the Federal Government paid 53.6 percent of the cost of Texas' Medicaid program. At the beginning of FY 1987, the first annual recalculation of Medicaid matching percentages occurred. Since the recalculation used per capita income data from the years 1983 through 1985, Texas' matching rate was increased to 55.2 percent, reflecting the economic conditions during that period. As a result of this matching rate change, the net increase in the demand on State funds to finance \$383 million in Medicaid cost increases in FY 1987 was only \$149.0 million, \$30.9 million fewer State dollars than would have otherwise been required. Texas' Federal matching rate was increased even further for FY 1988 to 56.9 percent, causing State Medicaid expenditures to be \$35.3 million less than the State would have spent at the FY 1987 matching rate.

### **Medicaid Growth Between FY 1988 and FY 1989**

In FY 1989, caseload increases, State-initiated Medicaid expansions, Federal mandates, and other factors nominally resulted in program costs \$318 million higher than in FY 1988. However, the net cost increase to the program was

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only \$255 million, since the provider reimbursement reduction was substantially still in effect and reduced costs by \$63 million. Of this \$255 million in program cost increases, \$57 million can be attributed to State-initiated expansions and \$38.6 million to Federal mandates. State revenue requirements for FY 1989 increased by only \$68 million over FY 1988 because Texas' Federal matching rate had increased again, causing the State's share of Medicaid costs to drop from 43.09 percent to 40.96 percent.

Texas' expenditures for FY 1989 established a new pattern in the State's Medicaid program that has persisted to the present. The Federal Government continued to create new options for expanding eligibility and began imposing major new Medicaid mandates on the States, while Texas began looking to the Medicaid program as a source of Federal dollars it felt it deserved.

By the beginning of 1987, Congress had created several additional State options for Medicaid eligibility not linked to eligibility for AFDC. The "decoupling" of Medicaid made eligibility expansions much more politically feasible, obviating the need for increasing welfare eligibility in order to increase the number of women and children eligible for medical assistance.

Despite the continued fiscal crisis facing State government, Texas officials responded positively to the first available option for Medicaid expansion. Lawmakers recognized an opportunity to pull in "free" Federal dollars through the new Medicaid options, fulfilling part of the State matching requirements by using State and local funds that were already being spent for providing health care to pregnant women and children. In its 1987 biennial session, the legislature authorized the use of existing State health care program dollars to partially fund an expansion and enhancement of services for pregnant women and children.



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In the fall of 1987, Lieutenant Governor William P. Hobby appointed a Select Committee on Medicaid and Family Services to recommend strategies for implementing the new Medicaid options and to identify all available opportunities for utilizing State and local funds to draw down additional Federal Medicaid matching funds. In the spring of 1988, this committee recommended several Medicaid expansions.

Upon the recommendations of this committee and in response to other efforts to improve Medicaid services for pregnant women and children, the Department of Human Services prepared to implement several State-initiated changes to Medicaid by the beginning of FY 1989. Before these changes could be implemented, Congress passed the Medicare Catastrophic Coverage Act of 1988, which mandated that States provide Medicaid coverage for pregnant women and infants up to age 1 with incomes up to 75 percent of the poverty level by July 1, 1989, and up to 100 percent of the poverty level by July 1, 1990.

Going beyond the Federal mandate, the State-initiated changes to Medicaid accomplished the following:

- Provided Medicaid to pregnant women and children up to age 2 with family incomes up to 100 percent of the poverty level;
- Increased reimbursement rates for obstetrical services;
- Placed children's hospitals under reasonable cost-reimbursement principles, exempting them from the maximum payments allowed under Texas' Diagnosis-Related Group (DRG) reimbursement system;

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- Allowed health clinics to receive Medicaid reimbursement for maternity services; and
  - Increased payments to hospitals by raising the standard dollar amount upon which payments for inpatient care are based from \$1,200 to \$1,500.

Most of the \$57 million cost increase was due to the expansion of Medicaid to pregnant women and children up to age 2 with poverty-level incomes, costing the State an additional \$42.6 million in FY 1989. The high cost of this one change in Medicaid policy was directly related to Texas' low AFDC standard of need. At the time this expansion occurred, Texas Medicaid recipients who were categorically eligible because of their receipt of AFDC had incomes at or below 22.8 percent of poverty compared with 82 percent of poverty in California and New York and 58 percent of poverty in Oklahoma.<sup>103</sup> Consequently, raising Medicaid eligibility levels to 100 percent of poverty was a bigger jump for Texas than for other States.

Several other Federal mandates with a significant impact also became effective in FY 1989. Federal law required States to:

- Pay out-of-pocket Medicare costs for certain low income elderly persons;
- Exempt infants up to age 1 from dollar limitations and the 30-day limitation on a hospital stay for a single spell of illness if inpatient

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<sup>103</sup>A Vision for America's Future: An Agenda for the 1990s: A Children's Defense Fund Budget, Children's Defense Fund, 1989, p. 137.

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treatment is provided by a hospital designated as a disproportionate share facility,<sup>104</sup>

- Reform nursing home care to improve quality of care; and
- Protect spouses of Medicaid recipients from having to impoverish themselves to pay for their mates' care.

In all, Federal requirements caused Texas' FY 1989 Medicaid costs to be \$38.6 million higher than in FY 1988.

To finance these State and federally initiated Medicaid expansions, the Department of Human Services required \$40 million in State funds. Prompted by the legislature's interest in using existing State dollars to draw down Federal funds, an agreement was reached between the Texas Department of Human Services and the Texas Department of Health under which \$15 million in State funds would be transferred from the health department's Maternal and Infant Health program to the Department of Human Services for use as State matching funds for the Medicaid expansions relating to maternal and child health care. The rationale for this transfer was that, with increased income eligibility limits, the Medicaid program would subsume a portion of the population that would otherwise have received services from the Maternal and Infant Health program, reducing the program's funding needs. The Department of Human Services used unexpended FY 1988 funds for the remaining \$25 million State matching dollars required to finance the FY 1989 cost of the expansions.

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<sup>104</sup>A disproportionate share facility is a hospital which meets certain State-defined criteria, allowing it to be designed as a hospital whose patient load contains a high ratio of indigent persons.

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Despite the usual implicit support from Lieutenant Governor Hobby for the FY 1989 Medicaid expansions, this action by the Department of Human Services elicited the strongest negative reaction of any of the expansions. The very existence of unexpended FY 1988 funds caused an uproar among legislators who had raised \$5.7 billion in new taxes in 1987 to prevent services from being drastically cut during the FY 1988-89 biennium and among the hospitals and physicians who had been providing Medicaid services at reduced reimbursement rates since the summer of 1986.

Health care providers argued that any unexpended Medicaid funds should have been used to restore the physician and hospital reimbursement rate cuts. They claimed that increasing Medicaid eligibility without restoring payment levels would cause them to lose money and result in providers dropping out of the program. Legislators, however, complained that the agency's expansions of Medicaid were committing the State to future expenditures and should not have been undertaken without explicit legislative approval. Despite these concerns, the legislature, meeting the following January, not only provided permanent funding for the FY 1989 Medicaid expansions but also approved additional State-initiated expansions.

## **Growth in Medicaid Between FY 1989 and FY 1990**

Texas' Medicaid costs grew 35 percent in FY 1990 at the fastest rate ever. At \$3.3 billion, FY 1990 expenditures were \$848 million higher than they had been in FY 1989. Several different influences converged during this period to cause costs to escalate at this rate.

First, the State legislature, during its January 1989 session, made several decisions which resulted in higher Medicaid costs. Besides funding the agency-initiated expansions which had been implemented in FY 1989,

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lawmakers chose to provide Medicaid coverage for children between ages 2 and 4 up to 100 percent of poverty and pregnant women and infants with incomes between 100 and 130 percent of the poverty level as of September 1, 1989. The cost of these initiatives, when coupled with the FY 1990 costs of FY 1989 initiatives, caused State Medicaid expenditures to be \$54.9 million higher than they had been in FY 1989. In addition, the legislature chose to increase the income eligibility limit for Medicaid nursing home care to the maximum allowed by Federal law, increasing FY 1990 spending by \$22.5 million over FY 1989 levels.

Lawmakers also hoped to relieve some of the problems of rural hospitals by providing facilities with 100 or fewer beds with a lump-sum payment at the end of their fiscal year equal to the difference between their payments under the DRG reimbursement system and those in accord with the cost-reimbursement principles in effect prior to DRGs. Finally, the legislature restored 3 percent of the 10-percent provider reimbursement reduction that occurred in 1986, costing \$29.2 million for FY 1990. The total cost in FY 1990 for Medicaid changes initiated by the State during this and previous fiscal years in the period was \$106.6 million more than that in the previous fiscal year.

Federal requirements also contributed to the jump in Medicaid costs for FY 1990. On April 1, 1990, several Federal mandates became effective, requiring Texas to:

- provide Medicaid coverage to pregnant women and children up to age 6 with family incomes up to 133 percent of the Federal Poverty Level and



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- provide Medicaid payment for any medically necessary treatment of conditions affecting children who are participating in the Early Periodic Screening, Diagnosis, and Treatment program.

Having subsumed several previous State initiatives, the cumulative FY 1990 impact of these federally mandated changes, when combined with the cumulative effect of FY 1989 mandates, was a total State and Federal cost increase of \$131.8 million over FY 1989 costs. In the area of nursing homes, Federal mandates, particularly nursing home reform requirements and the first minimum wage hike, caused FY 1990 costs to increase \$81.7 million over the previous year's costs. In all, Federal mandates accounted for close to \$213 million of increased costs in FY 1990 compared with those of FY 1989.

FY 1990 saw the beginning of another trend in Texas' Medicaid program which would account for evergrowing proportions of future Medicaid spending increases. Having embarked in 1987 on the search for ways to increase Texas' Medicaid services using existing State and local dollars to generate Federal matching funds, Texas continued and broadened this search during subsequent years. The impetus behind this effort was twofold. Most obviously, Texas hoped to find ways to improve services without having to dedicate large amounts of State revenue.

State officials were also trying to find a way to retrofit a California-style State and local partnership into Texas' Medicaid program. In Texas, local governments frequently provide health care to medically indigent persons in their jurisdictions. The Texas constitution even provides a special taxing authority to local hospital districts to operate public hospitals. State officials hoped to find some way to utilize those local health care dollars as State matching funds to expand the Medicaid program.

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Most proposals for accomplishing this goal were politically infeasible. Between Federal funding cuts and State cost-shifting, local governments were already feeling overburdened. By the very nature of the Medicaid program, one could not guarantee that local funds appropriated by the State for use as matching funds would return to the local health care facility in the form of reimbursement payments for expanded Medicaid services. Under Federal law, recipients are allowed freedom of choice of providers. While they might have used a local public health care facility when it was the only care accessible to them, once they are receiving Medicaid, they can and may go elsewhere for treatment.

In 1989, the legislature approved the FY 1990 implementation of the only use of local funds that was found to be politically possible. Legislation was passed, assessing a tax on certain publicly funded hospitals. The funds collected through this assessment were used as State matching funds for the Texas Disproportionate Share program.

Under the federally mandated disproportionate share program, hospitals which serve a disproportionate share of indigent patients are provided an incremental increase to their payments to partially offset the higher operating costs associated with serving a poorer patient population. Under a statutory exemption from portions of the Federal law, Texas makes an annual lump-sum payment to disproportionate share hospitals rather than making incremental adjustments to hospital reimbursement payments. In FY 1989, Texas' disproportionate share program distributed the first \$4.9 million in payments to qualified hospitals.

In FY 1990, Texas' disproportionate share program payments totaled \$35.1 million. The newly implemented hospital assessment provided \$6.6 million in public hospital funds, which were matched by \$10.5 million

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in Federal dollars, and disbursed them to qualified facilities. Due to the fact that they served large numbers of indigent patients during FY 1990, all hospitals which were assessed a tax under the new State law received disproportionate share payments that were at least equal to their assessments.

Caseload, inflation, and per recipient cost increases accounted for more than 60 percent of the increase in FY 1990 costs over FY 1989 expenditures. Categorically eligible AFDC-related Medicaid recipient caseloads grew substantially during this period. In this category of recipients alone, FY 1990 average monthly caseloads were 68,500, or 11.6 percent higher than in FY 1989. The combined effect of caseload growth, inflation, the increase in per recipient costs, and the rise in disproportionate share payments was an increase of \$528 million in FY 1990 costs over expenditures for FY 1989.

State revenues required to finance this growth were again offset somewhat by another increase in the State's Federal matching rate. In FY 1990, Texas' share of its Medicaid program costs dropped below the 40-percent mark, falling to 38.77 percent. The decrease in the State's share from 40.96 percent the previous year caused Texas' costs to be \$67.2 million less than they would have been at the previous rate. Thus, of a total FY 1990 cost increase of \$848 million over FY 1989, Texas' costs were only \$276.2 million higher.

## **Medicaid Growth Between FY 1990 and FY 1991**

Texas Medicaid costs for FY 1991 showed a dramatic increase of more than \$1 billion over those of FY 1990. The cumulative effect from FY 1988 through FY 1991 of Federal mandates accounted for the largest portion of the increase, costing the State and Federal Governments \$517 million more in FY 1991 than in the previous year. The cumulative effect of changes

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initiated by the State during the same period was an increase in FY 1991 of \$120.6 million over FY 1989 costs. In FY 1991, Texas' disproportionate share hospital payment program spent \$332.5 million more than it had in FY 1990, and provider payment increases accounted for an increase of \$44.4 million over expenditures for the previous fiscal year.

While previous federally mandated Medicaid expansions continued to contribute to cost increases, several additional mandates became effective in FY 1991. As a result, Federal mandates accounted for the largest single source of increases in costs over FY 1990 levels. Among the federally mandated changes in Medicaid for FY 1991 were requirements to:

- provide Medicaid to the newly eligible AFDC unemployed parents;
- cover children with family incomes up to 100 percent of poverty who were born after September 30, 1983, until they reach age 19; and
- eliminate length-of-stay limitations and maximum dollar payments for the hospitalization of infants and for children up to age 6 who are in hospitals designated as disproportionate share hospitals.

In FY 1991, other Federal actions caused Texas' Medicaid costs to rise. During this fiscal year, the State received Federal policy clarifications which liberalized the State's interpretation of the Federal statutes regarding changes to the Medicaid EPSDT program and the eligibility of newborns for Medicaid. Federal minimum wage hikes caused nursing-home and home health care payments to increase during this period. Texas also settled out of court a lawsuit brought by the State's nursing home association on the basis of the "Boren amendment," claiming that the State's reimbursement rates were not reasonable as defined under that provision of Federal law. When

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combined with the effect of previous Federal mandates, federally induced changes in Texas' Medicaid program during FY 1991 caused that fiscal year's cost to be \$517.7 million higher than in FY 1990.

In FY 1991, Texas was in the second year of its biennial budget cycle, and the Department of Human Services did not initiate any Medicaid expansions. In the 1989 legislative session, State lawmakers had authorized the restoration of an additional 1.5 percent to the 1986 provider reimbursement rates. This single change, combined with the cumulative effect of previous State Medicaid initiatives caused Texas' costs to be \$165 million higher in FY 1991 than in FY 1990.

In FY 1991, Texas significantly expanded its disproportionate share program, both increasing the assessment on the original public hospitals and implementing an additional component. By increasing the assessment on public hospitals, Texas acquired \$35.9 million in funds to use as State matching funds. When combined with the \$7 million in regularly appropriated revenues, these local funds brought in \$74.8 million of Federal matching funds which were distributed to disproportionate share hospitals.

The new component of disproportionate share, which was approved by the U.S. Health Care Financing Administration and implemented in FY 1991, involved State-operated teaching hospitals. Under this new component, called "Dispro. II," Texas transferred into the Medicaid disproportionate share program \$72.1 million in funds originally appropriated for the operation of University of Texas teaching hospitals. Using this money as State matching dollars, the State obtained \$125.5 million in Federal matching funds during FY 1991.



# Medicaid Cost Increases by Source 1986 - 1991

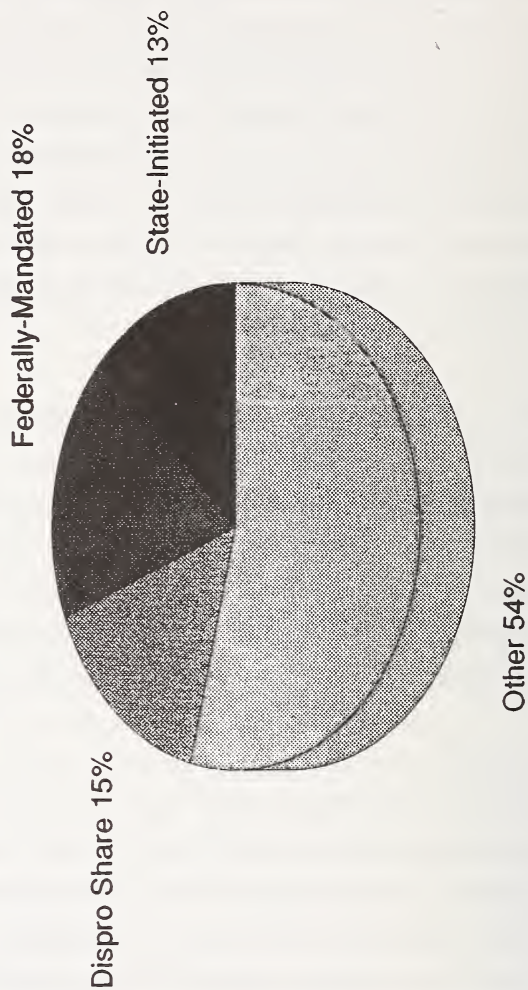


Figure 3

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In addition, as required by State legislation passed in the summer of 1991, the Department of Human Services submitted yet another disproportionate share component for approval by the Health Care Financing Administration. This proposal, known in the State as "Dispro. III," creates an additional provider assessment for "significant Medicaid hospitals." Twenty-four hospitals meeting the criteria under the new law would be assessed 1.25 percent of their non-Medicaid inpatient revenue every month. The revenue obtained through this assessment would be matched with Federal funds and then distributed back to Dispro. III hospitals on the basis of the number of Medicaid days of care provided by each facility. If approved by the Federal Government, Dispro. III would bring an additional \$33.2 million in Federal funds in FY 1991 payments to hospitals, since it would only have been operational for the last 25 days of the fiscal year.

In FY 1991, for the second year in a row, the caseload for categorically eligible, AFDC-related Medicaid recipients increased significantly. From FY 1990 to FY 1991, the average monthly caseload for this group rose 87,911, or 10 percent. During the same period, the monthly cost of providing coverage to pregnant women and newborn infants rose 18.3 percent. These developments, when combined with the increased expenditures in the various disproportionate share programs, caused Texas' Medicaid costs to be \$380 million more in FY 1991 than they had been in FY 1990.

Cost increases in FY 1991 were further offset by another hike in the Federal matching rate for Texas' Medicaid program. Texas' Federal matching rate increased for FY 1991 to 63.53 percent. As a result of this increase, Texas' own-source revenue costs were \$94 million lower than they would have been under the previous year's matching rate.



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## **Projected Cost Increases for FY 1992 and FY 1993**

Texas anticipates a continued trend of spiraling increases in Medicaid expenditures into the next biennium. Estimated FY 1992 expenditures are expected to increase \$2 billion, or 46 percent over those in FY 1991.

In its 1991 session, the legislature initiated the following changes to the program that will result in increased costs:

- expansion of Medicaid to include pregnant women and infants with incomes up to 185 percent of poverty as of March 1, 1992, at an anticipated cost of close to \$40 million for the biennium;
- restoration of the remaining 5.5 percent of the 10-percent provider reimbursement rate reduction that occurred in 1986, at a cost of \$278 million for the biennium;
- removal of the assets test for Medicaid eligibility for pregnant women, increasing costs by \$5.6 million for the next 2 fiscal years; and
- expansion of Medicaid coverage to include dental sealants at a cost of \$3.6 million for the biennium.

Federal and State changes in the EPSDT program are expected to begin to be felt in the next biennium, increasing costs by a total of \$65.6 million in FY 1992 and \$191.8 million in FY 1993. The largest portion of this increase in EPSDT costs is due to the fact that Texas' original implementation of the 1989 Federal law changes was more restrictive than HCFA's final interpretation.

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Of the \$2 billion increase anticipated in FY 1992, \$900 million is expected to occur in the Medicaid disproportionate share program. The cost of the three components of the program would increase from a total of \$367.6 million in FY 1991 to \$1.2 billion in FY 1992. In addition, the State anticipates implementing another component in FY 1992. This new component, known predictably as Dispro. IV and designed to aid rural hospitals, would utilize 5 percent of the funds collected from the Dispro. III hospitals as State funds in Dispro. IV, increasing total disproportionate share expenditures by \$40.9 million.

The legislature also utilized disproportionate share as a source of State funds to finance the increase in other components of the Medicaid program. For the FY 1992-93 biennium, the State plans to use \$250 million in funds originally obtained through the Dispro. II program as State matching funds for other Medicaid services, drawing down, at the FY 1992 matching rate, an additional \$448 million in Federal funds.

Using this strategy, Texas hopes to obtain \$800 million in Federal funds in FY 1992 using funds obtained from hospital assessments as the State share. In addition, the State plans to use \$125 million of these funds as State matching funds in other Medicaid programs, obtaining an additional \$224 million in Federal funds. In total, the State expects to receive over \$1 billion in Federal funds during FY 1992 without having appropriated additional State general revenue dollars.<sup>105</sup>

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<sup>105</sup>At press time, Congress, the U.S. Department of Health and Human Services Health Care Financing Administration, and officials of various States, were negotiating an agreement which is likely to reduce the amount of Federal Medicaid funds available through State disproportionate share programs.

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# Texas State and Federal Expenditures

## 1986 - 1992 (Projected)

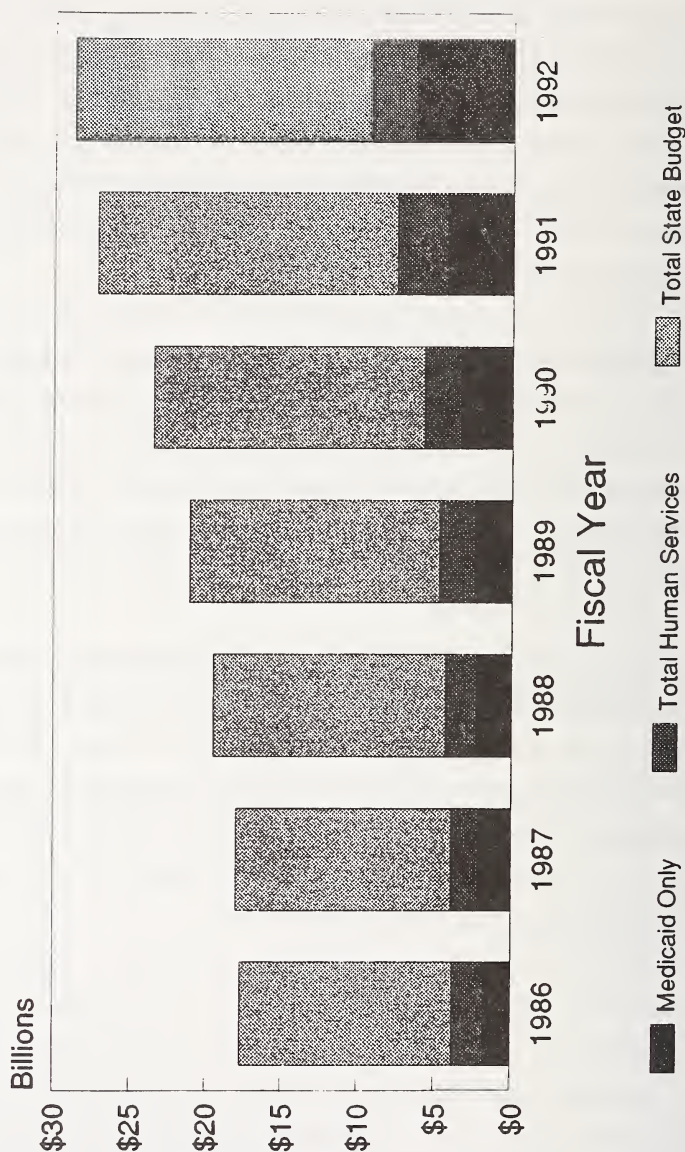


Figure 4

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## The Effect of the New Medicaid Eligibles on Utilization

Although documenting data are not available, many speculate that the creation of new groups of Medicaid recipients during the last several years has changed trends in health care utilization, causing costs to escalate faster and to be less predictable. Utilization of services had remained relatively steady over time so long as Medicaid recipients were almost all categorically eligible. Recipients were enrolled in Medicaid automatically upon being granted financial assistance and would access health care services at a fairly predictable rate according to when they became ill. The new eligibility groups, on the other hand, frequently only sought Medicaid coverage upon becoming ill or in anticipation of requiring services. Thousands of women became eligible for Medicaid solely because they were pregnant. Since this coverage is designed to encourage adequate prenatal care, its recipients by definition would be much greater utilizers relative to categorically eligible recipients.

The children's coverage had somewhat similar effects. Frequently, children eligible for this coverage would apply for Medicaid only upon becoming ill and incurring costs with a hospital, clinic, or physician. Since Medicaid will pay bills for care received up to 3 months prior to the date of eligibility, the facility or physician would insist that patients apply for Medicaid if they did not have private insurance.



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## **Concluding Observations**

### **Medicaid as a Method of Finance**

Enormous changes have occurred over the last several years, not only in the groups served and services offered in Texas Medicaid program but also in the State's attitude toward the Medicaid program. Medicaid has changed from a financial assistance program for individuals to a method of finance for the State. Even in the midst of the worst budget crises and in the wake of the most significant Federal mandates, Texas has voluntarily increased Medicaid spending to draw down Federal dollars.

Although Medicaid cost increases have occurred concurrently with years of State budget crises, Texas' fiscal problems cannot be said to have been caused by increases in Medicaid. Rather, the State has frequently used Medicaid as a method of bringing additional Federal funds into the State and easing its revenue problems. The availability of Federal matching funds in any program has come to be the best argument for improving or expanding that program.

### **The Effect of Medicaid Cost Increases on Other Services**

Despite the furor over Federal Medicaid mandates, growth in Medicaid costs does not appear to have caused other program budgets to be cut except to the extent that other State health programs' clients became eligible for Medicaid as a result of expansions, decreasing those programs' funding needs. Only minor increases occurred in other health and human services programs during the 5-year period. However, the lack of growth in other programs cannot be attributed to Medicaid's claim on resources.

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Given the history of the State's funding priorities and severity of its fiscal crises over the period, it is unlikely that health and human services programs would have received substantial appropriations increases in the absence of Medicaid's growth in costs. Those who were involved in Texas government prior to the collapse of the oil economy often refer to the times when State officials did not know how to spend all the revenue that was generated. Yet, even in those times, Texas did not provide increases to health and human services programs. The average monthly grant per recipient in the Aid to Families with Dependent Children program was \$32.47 in 1978 and had been raised to \$34.17 by 1983, an increase of only 5 percent over a 5-year period. During this same period, Texas was experiencing its greatest state revenue growth, with receipts increasing an average of 12.7 percent annually.

Although it is possible that without the pressure of federally mandated Medicaid spending increases, the legislature would have been more attentive to the funding needs of other programs, it is unlikely. In many of the years in question, State officials who made funding decisions cared primarily about two issues: (1) whether an increase in State funding results in additional Federal dollars for the State, and (2) whether Federal law requires that the State provides the service in question. The extent to which Federal and State Medicaid decisions have influenced other programs is primarily in prejudicing State officials against providing new funding for any program that does not have Federal matching funds available.

## **The Lure of Federal Funds and the Imperatives of Public Policy**

The cost increases in Texas' Medicaid program over this period were driven by numerous influences. Ultimately, what is most significant for future public policy is not the magnitude of cost increases nor the cause of those



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increases. The more important considerations are how Texas and the Nation will cope with the burgeoning ranks of uninsured and how Federal funding availability will shape the States' health care policies.

Over 3 million Texans are believed to have neither private insurance nor access to public medical assistance. The growth in Medicaid costs is at least in part a consequence of this larger crisis and may, in fact, have forestalled a more severe health care crisis. In the meantime, the cost of emergency services to those who have no health coverage is contributing to the rise of health care costs, not only for State Medicaid programs but also for individuals and businesses with private insurance. Medicaid costs cannot be contained in a vacuum. A comprehensive solution to the Nation's health care crisis is the only method of controlling the rate of Medicaid cost increases.

Until a comprehensive solution is available, States will increasingly view Medicaid as a method of finance. The fiscal stress being experienced by State and local governments and the increasingly pressing problems of access to health care make the availability of Federal Medicaid dollars a primary motivation for health policy decisions. Since Medicaid funding is available for the coverage of only limited groups, future decisions on health care expansions may not reflect service priorities so much as they do the availability of Federal funding. Federal policymakers must consider how the lure of Federal funding availability can drive State policy, particularly as the Nation's health care system becomes increasingly fragile.

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# **Utah: Medicaid Cost Increases**

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## Introduction

Utah Medical Assistance in the Department of Health includes three programs: the Utah Medicaid (Title XIX) Program, Title XIX funding for Department of Human Services programs, and the Utah Medical Assistance Program (UMAP). Medicaid is a joint Federal-State entitlement program to provide medical care to specific populations of low income people. Most of the persons covered and the services offered by the State are mandated in Federal law or regulations. Some programs of the Department of Human Services qualify for Medicaid (Title XIX of the Social Security Act) funding when the people receiving the services are Medicaid eligible. State funds for these services are appropriated to the Department of Human Services and are transferred to the Medical Assistance Program in the Department of Health as a dedicated credit. The Utah Medical Assistance Program (UMAP) is a 100-percent State-funded program to provide limited health care to some persons who do not qualify for other medical assistance programs.

The three Medical Assistance programs in the Department of Health are administered by the Division of Health Care Financing. The administrative costs are appropriated in a separate line item to the Division.

The budget for Medical Assistance in FY 1986 was \$203,767,000. The appropriated amount for FY 1992 is \$381,646,200, an increase of \$177.9 million, or 87.3 percent. Medical Assistance was 7.7 percent of the entire budget in FY 1986. In 1992, it has a 10.6-percent share, a significant increase. In contrast, the budget for Higher Education during the same period, a period of 30-percent enrollment growth, grew only 30.6 percent. Higher Education's share of the total State budget decreased from 12.4 percent in FY 1986 to 11.9 percent in FY 1992.

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The allocation of the \$203.8 million appropriation in FY 1986 among the three programs and the Health Care Financing administrative line item are not readily available. Therefore, this document will analyze and discuss the historical aspects of Medical Assistance funding for the period FY 1987-92 and projections through FY 1997.

Utah's economy has not followed national trends the past few years. Utah experienced an economic downturn during the 1987-88 period and has had strong economic growth since that time. As a result, the growth in Medical Assistance during the FY 1987-89 period was minimal. Figures for FY 1988 were actually lower than for FY 1987. However, over the last 3 years, from FY 1989 to FY 1992, Medical Assistance has grown dramatically. The average annual growth rate has been 21.8 percent, with the FY 1992 increase of 17 percent being the lowest. However, there is likely to be a supplemental appropriation for Medical Assistance in FY 1992; hence, that percentage should increase. The Governor has publicly called for some additional appropriation out of the State's recently announced \$30 million FY 1991 surplus to prevent or delay program cuts from taking place. Those program reductions will be discussed later.

## **Impact of Medicaid Funding**

Utah has a unique education challenge. Ranking first in the Nation, 27 percent of Utah's population is of school age. The corresponding figure for the second-ranking State is only 22 percent. Utah has seen dramatic growth in its school-age population over the last decade. As a result, Utah spends less per student than any other State in the Nation. The dramatic growth has begun to reach the higher education system.

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The growth in Medical Assistance, primarily federally mandated, has been 65.4 percent, or \$150.8 million, since FY 1989. Despite continued dramatic enrollment growth in public education, the FY 1989-92 increase for public education was only 43.5 percent. The federally mandated and inflationary increased costs in Medicaid have reduced the State's ability to deal with the educational challenges and other critical State needs.

The growth in Medicaid has also affected other health and human service programs. The same legislative committee, the Human Services and Health Appropriation Committee, deals with all programs in the Departments of Health and Human Services. As a result, the committee has been faced with some very difficult choices.

The Aid to Families with Dependent Children (AFDC) Program, a joint State/Federal program to provide assistance for children who have been deprived of the support of at least one parent, has been affected by the growth in Medicaid funding. Although AFDC has the same Federal match rate as Medicaid—75 percent—AFDC funding has grown only 28.2 percent since FY 1987, while Medicaid funding has grown 96.7 percent over that same 5-year period. In the last 5 years, grant levels for the AFDC program have increased by an average of 1.4 percent per year. There have been no increases in 3 of the 5 years, largely because of the competition and pressure of Medicaid funding. Over the years, Federal Supplemental Security Income (SSI) grants have been inflated by a cost-of-living index, while the AFDC grants have not. As a result, there is a marked difference in the amounts received by AFDC grant families and SSI grant families. The 1991 SSI grant levels for one and two persons are \$407 and \$610, respectively, compared with \$224 and \$310 for the AFDC Program. AFDC grant levels are just over half as much as the SSI grants.



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State programs have also been affected by Medicaid growth. The Utah Medical Assistance Program (UMAP), a fully State-funded medical program providing limited medical care for persons with income below 133 percent of the AFDC grant for the family size and who have medical conditions which are life threatening or infectious, has been particularly affected. The UMAP appropriation for FY 1992 is 27 percent less than the expenditures for FY 1987. In FY 1988, a trade was made with the hospital industry to transfer State general funds from UMAP to Medicaid in exchange for reduced charges to hospitals. This allowed Medicaid to increase reimbursement to hospitals for Medicaid services. The agreement was for 1 year. However, because of continued Medicaid cost increases, the State general funds have never been restored to UMAP. Given pressures for State general funds to support the Medicaid Program, it appears unlikely that the UMAP Program will receive a restoration of State general funds or experience significant growth in the foreseeable future.

The reductions in funding for UMAP represent real service reductions to the extent persons cut from the Program have not been treated by hospitals as charity or uncompensated care cases. The UMAP Program provides limited medical care for individuals who have life-threatening or infectious conditions and do not qualify for Medicaid or any other medical assistance program. The UMAP is the State's medical safety net. If individuals fall through that net, no other programs exist to meet their medical needs.

The programs which seem to be affected most by increased demands for Medicaid funding are those supported totally with State funds. UMAP is an example. Another State program which has been impacted by Medicaid is General Assistance, a fully State-funded program which provides assistance to individuals and couples without children who are unable to work for medical reasons. Single recipients in 1991 receive combined assistance of 61

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percent of the Federal poverty level. The assistance level is \$233 in addition to qualifying for \$105 in food stamps.

Since 1987, Medicaid funding has increased nearly 97 percent. Public assistance programs in total have increased 74 percent over that same period. On the other hand, General Assistance has only increased 35 percent. The General Assistance Program emphasizes efforts to become self-sufficient. In spite of that laudable goal, funding for the program has not kept pace with increased needs. Funding for General Assistance is discretionary and not mandatory like much of Medicaid. Hence, Medicaid has received most of the funding increases.

In the summer of 1990, after the legislative session, it became clear that the Utah economy was performing above expectations. A surplus was generated for FY 1989-90, and the upturn was projected to continue. As a result of the budget pressures which had been created by Medicaid growth, the Governor called legislative leaders together and proposed that they commit to fund an \$8 million supplemental appropriation for Medicaid programs and other Health and Human Resource programs which had been underfunded because of the Medicaid funding pressures. When the legislative session convened in early 1991, the economy had continued to expand beyond projections and the Governor and legislature increased the one-time supplemental for Health and Human Resource programs from the \$8 million committed level to \$12 million with the hope that ongoing funding would be available in FY 1992 to continue all services.

In addition, the ongoing FY 1991-92 appropriation for Health and Human Resource programs was increased about 15 percent, double the increase in revenues of about 7 percent. The majority of the increases went to Medicaid. The cost of additional Federal requirements was estimated at \$52 million,

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including \$13 million in State general funds. Despite the relatively good economy and the supplemental appropriations, the legislature was able to fund only about \$10 million from the State General Fund; the remaining \$3 million in State matching funds was required to come through cuts in optional areas of the Medicaid program. Eight program reductions as cost-containment measures were adopted to provide the required State match for Medicaid. The reductions were the following:

- reducing payments to Primary Children's Medical Center to levels paid by other hospitals for the same services;
- eliminating adult bone marrow transplants;
- eliminating case-management fees for physicians;
- reducing reimbursement for vision, speech, and audiology services;
- eliminating approximately 3,000 people who would qualify for the Medically Needy Program under the AFDC category of eligibility;
- reducing services available to the Medically Needy;
- eliminating the spend-down program in UMAP, a totally State-funded program; and
- reducing hospital coverage under UMAP.

When it appeared that Utah would again have a surplus at the end of FY 1990-91 despite the legislature appropriating all projected additional revenue as supplementals, the Governor postponed implementation of the last four

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program cuts. The Governor has promised to support and push through a supplemental appropriation sufficient to at least cover those postponed cuts for one more year. The postponement may be only temporary, as it is doubtful that the economy will continue at a pace permitting continued funding of those four programs and funding projected Medicaid-mandated increases in FY 1992-93.

The increased Medicaid-mandated costs had caused the hospital reimbursement rate to drop to 60 percent of charges for FY 1991. To attempt to address that problem, and following the lead of their States, a voluntary contribution of \$4.2 million was received from hospitals to permit the drawdown of matching Federal funds. As a result, all hospital claims for FY 1991 were rerun, and hospital reimbursements were increased to approximately 78 percent of charges. That was done with the knowledge that Federal regulations were expected shortly curtailing the use of voluntary contributions and provider taxes.

Hospital reimbursement rate levels will again be an issue at the next general session of the legislature. Hospitals had agreed to continue funding their voluntary contributions, including inflationary increases. However, the new Federal limitations will likely require that some type of general tax affecting the medical community replace the voluntary contributions, or the hospital reimbursement rate will have to be reduced.

The cost and growth of the Medicaid Program are a function of the services offered, the amount paid for each service, and the number of people covered by the program. Each of these factors has been affected by recent Federal legislation or regulation. While inflation has played a major part in increased costs, a review of each of the factors above has clearly shown that in Utah the increased Medicaid costs have been primarily a function of utilization



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increases mandated by the Federal Government and not a function of cost increases.

## Projections

Medicaid expenditures are projected to continue to eat up, PAC-Man-like, available State resources. In FY 1987, the Medical Assistance Program was 8.5 percent of the total State budget. That percentage has grown to 10.6 percent appropriated in FY 1992. By FY 1997, Medical Assistance is projected to be over 16 percent of the total State budget. That projection assumes that the Utah economy will continue at its strong pace, with State tax dollars increasing about 7 percent per year. If the State experiences another downturn in the economy, as it did in 1987-88 and as many States are now experiencing, continued mandated Medicaid expansions will mean an even greater share of the State's funding pie for Medical Assistance Programs.

The concern in Utah about the growth of the Medical Assistance Programs, primarily Medicaid, is not only the relationship to the overall State budget but also the impact on other programs in the Departments of Health and Human Services. Currently, Utah's Public and Medical Assistance Programs comprise about 6.4 percent of the General/Uniform School Funds. By FY 1997, the Office of the Legislative Fiscal Analyst estimates that those programs will grow to 9.2 percent. However, Medical Assistance is projected to grow from just over 4 percent to about 7 percent, while Public Assistance will actually drop from 2.4 percent to 2.2 percent. Again, those projections assume that the Utah economy will continue to outperform the rest of the Nation. If the economy slows, the impact of Medicaid mandates will be even more severe and devastating.

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The result of the budget pressures caused by a rapidly escalating Medicaid budget is that even with a relatively good economy projected to continue in Utah, provider rates will continue to suffer and cuts in other programs will result. Projected Federal Medicaid mandates will strain Utah budgets over the next decade if the Utah economy remains strong. If the local economy slows much, expected expansions in Medicaid will likely break the bank. Utah has used and is currently using all three of the traditional cost-containment initiatives: limiting access by controlling eligibility, eliminating services, and limiting payments to providers. There are not enough expenditures in optional services or eligibility categories to significantly slow the growth of the Medical Assistance Program if all optional portions are eliminated. If the economy slows, which it will do at some point if history repeats itself, all optional programs will likely be eliminated. Utah will have no choice at that point but to further limit access through eligibility, further eliminate services, and further reduce payments to providers.

The prospects in the very long term are even more disturbing if something fundamental is not done to change the system. Some projections show that national health expenditures will continue to grow as a percentage of the gross national product (GNP). If health expenditures as a percentage of GNP more than double over the next 40 years as projected by some, the entire fabric of governmental services will be in danger of unraveling. The impact on Utah, with its unique demographics and age structure, will be particularly damaging to public and higher education as well as harmful to other government services.

Medicaid growth is imposing some very difficult decisions on State government officials in Utah. Decisions will become even more difficult over the next decade, particularly if the economy falters. Hopefully, the

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Federal Government will address those difficult decisions as well. Congress has improved access to health care through recent legislation. That trend is expected to continue. However, none of the legislation has addressed restructuring the health care system or introduced significant cost control measures.

What level of services can the States and the Nation as a whole afford? That issue must be addressed. Is medical assistance the primary or most pressing need we face? If the allocation of State funds to Medical Assistance programs reduces the amount available for basic Aid to Families with Dependent Children (AFDC) and General Assistance grants so that they do not provide adequate food, clothing, and shelter, will the poor have been well served? If the allocation of State funds to Medicaid does not permit adequate funding for education, educational reform, or protective services, will the children have been well served?

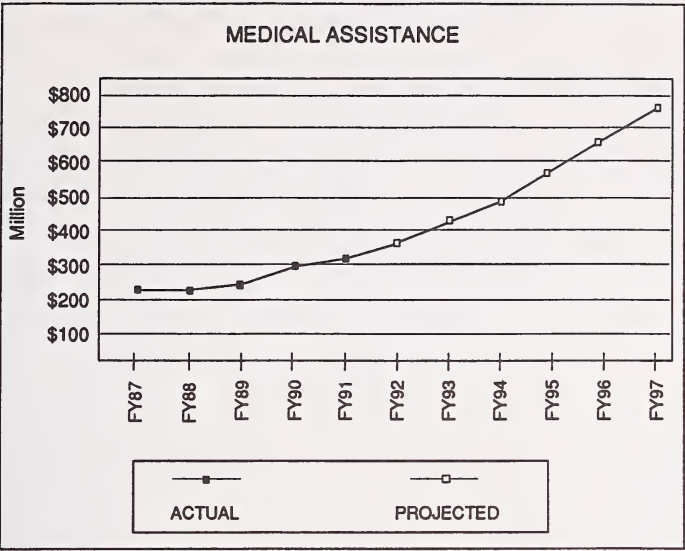


Chart 1

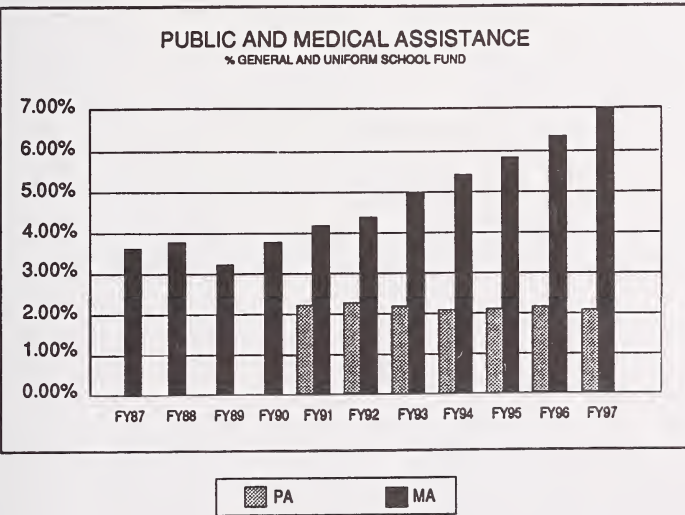


Chart 2



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